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ABSTRACT

The third of a series of four needs assessment related documents provides information on 17 innovative programs for children and youth in the areas of juvenile delinquency prevention and diversion, child abuse and neglect, day care, and child health care. Each project is reviewed in terms of the following areas: project cost, source of funding, target population, project goals, overview of project operation, innovative aspects of the project, project results/recommendations, and sources of further information. Project entries are presented alphabetically by title within subject areas. Among the programs covered are the Adolescent Diversion Project (Urbana and Champaign, Illinois), the Family Stress Center (Chula Vista, California), the Greeley Parent Child Center (Greeley, Colorado), and the Infant Intensive Care Project (Nassawadox and Norfolk, Virginia). Also included is a listing of funding information for programs for children and youth. (SBH)

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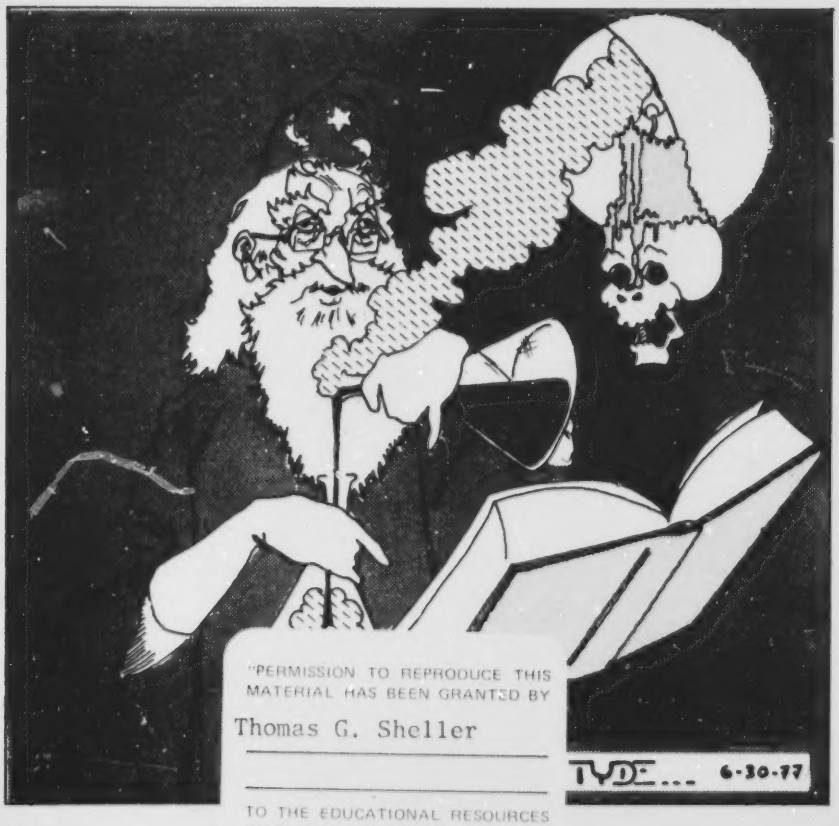

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Thank you for your time and effort in providing feedback.

Foreword

In an effort to assist those agencies and organizations which are directly responsible for delivering services--in particular, those agencies providing services to children and youth--the Virginia Commission for Children and Youth has developed a series of four documents which, hopefully, will assist in the delivery of human services.

The documents are intended to provide agencies/organizations with the necessary framework within which they can conduct a needs assessment. The four documents that have been developed are:

1. An Inventory and Analysis of State Data Sources for Children and Youth: Virginia
2. An Inventory of Legislation Affecting Children and Youth: With Selected Analyses
3. Innovative Programs for Children and Youth
4. Alternative Needs Assessment Techniques: Virginia

These documents were developed under the assumption that the following informational concerns must be addressed before agencies can effectively conduct a needs assessment:

1. what information is available and where is this information located?
2. what resources are available to provide services?
3. what legislation impacts on the delivery of services?
4. what alternative/innovative program and service delivery approaches are available?
5. what alternative techniques are available for conducting a needs assessment?

While each of the four documents can be used separately according to the needs of the user, the documents are intended to be used together. Collectively,

they attempt to address the above five categories of informational concern. However, aside from the "Alternative Needs Assessment Techniques" document, the documents address these concerns only to the extent that they relate to the target group "Children and Youth."

This project would not have been possible without the financial and technical assistance of numerous agencies and individuals. The project was funded through a Title XX contract with the Virginia Department of Welfare. During the search of the literature in developing this document, reference material was provided by the Virginia Department of Welfare, the Virginia Department of Health, the Virginia Division of Justice and Crime Prevention, the Virginia Department of Education, and the Offices of Child Development and Youth Development, Department of Health, Education and Welfare.

A special acknowledgment is in order to Mr. Richard Ruopp, et.al, authors of the book, A Day Care Guide for Administrators, Teachers and Parents (MIT Press: 1973), whose book was extensively used in developing the section on Day Care.

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INTRODUCTION

Overview

The effective delivery of human services is a complicated and ever-evolving process. In its most general sense, this process entails five distinct, yet interrelated, components or steps: 1.) assess the community needs, 2.) plan programs to address the identified needs, 3.) implement programs and services to meet the identified needs, 4.) evaluate the effectiveness of the programs and services, and 5.) adapt alternative/innovative programs to more effectively meet community needs.

While the service delivery process components logically follow one another in a sequential ordering (i.e., needs assessment, service planning, service delivery, program evaluation, program restructuring), they are, nevertheless, activities that entail on-going attention. Assessment of community needs must be a continual activity in order to ensure services that respond to changing needs or conditions, while both program planning and evaluation are conducted simultaneously with the delivery of services. In essence, each component is continually overlapping and affecting each of the others.

Moreover, the absence of any one of these components has an adverse effect on the conduct of each of the other components and, ultimately, on the ability of the process to achieve its intended end result--the most effective delivery of services to meet the needs of the community. For example, the omission of the needs assessment component severely restricts the ability to comprehensively plan services to meet community needs because the needs have not been identified. Likewise, the absence of program evaluation precludes the consideration of the need to restructure programs or services because the effectiveness of existing services has not been established.

In most instances, because of limited staff, time and financial resources, agencies and organizations responsible for delivering human services are not capable of conducting the five components of the service delivery process as comprehensively as is desirable. In particular, needs assessment, program evaluation and the implementation of innovative programs are often either not conducted at all or conducted only in the most cursory of fashions. Nevertheless, in order for Virginia to deliver human services in the most effective and efficient manner, greater emphasis needs to be placed on these program components.

Purpose

This document, "Innovative Programs for Children and Youth", is concerned primarily with the question--"what alternative/innovative programs and service delivery approaches are available in order to provide services to children and youth?" It is hoped that this document will alert agencies/organizations to the vast array of innovative approaches for delivering services to children and youth.

A review of the literature confirmed our assumption that there are numerous examples of excellent innovative programs in virtually every area of service delivery to children and youth. Rather than provide brief sketches of many innovative projects, the decision was made to select and explore in depth the areas of: Juvenile Delinquency Prevention and Diversion, Child Abuse and Neglect, Day Care, and Child Health Care.

Juvenile Delinquency Prevention and Diversion was selected because of the recent Juvenile Code revision and the resultant focus on diversion. Recent studies demonstrating the effectiveness of preventive programs (i.e., parenting education, early periodic screening, diagnosis and treatment) in reducing potential child abuse and neglect and poor nutrition and health, prompted the inclusion of Child Abuse and Neglect and Child Health Care. The steady increase in the numbers of working mothers and single-parent families suggests the likelihood for increased Day Care Programs.

The 17 projects included in this document were reviewed in terms of:

1. Project Cost
2. Source of Funding
3. Target Population
4. Project Goals
5. Overview of Project Operation

6. Innovative Aspects of Project
7. Project Results/Recommendations
8. Source of Further Information

It should be emphasized that this document is intended neither to present all the possible programmatic innovations currently available for service delivery to children and youth nor to specifically identify and include innovative projects operating in Virginia. Further information regarding innovative projects for children and youth is available from the respective local, State and Federal agencies having programmatic responsibilities (e.g., innovative education projects can be obtained from local School Boards, State Board of Education, or Office of Education, Department of Health, Education and Welfare).

For those agencies/organizations interested in pursuing the implementation of any of the discussed innovative projects, or any other projects, there is included at the end of this document a listing of information regarding the availability of funding for programs for children and youth.

The page numbering system of this document has been designed to incorporate all of the documents. To adequately distinguish the different documents with respect to the different sections, the first number is the document number; the second number represents the section or chapters of the document; and the third number is the page number of the particular section.

The goal of this document is not to provide answers: rather, it seeks to stimulate interest in improving service delivery to children and youth and their families. Too often it is easier to maintain the programs and services currently being provided, regardless of their effectiveness. There are over 100 localities in Virginia, and 49 other states in the United States that are potential repositories of innovative programs adaptable to your locality. Whether your locality merely presents services to children and youth, or whether it provides the most effective services, is dependent on the extent to which your locality is willing to investigate the best alternatives available.

JUVENILE DELINQUENCY
PREVENTION
&
DIVERSION

Project Name:	The Adolescent Diversion Project (ADP)
Project Location:	Urbanna and Champaign, Illinois
Recipient Agency/Organization:	University of Illinois
Project Duration:	1972-1976 (1972-73 was a "pilot" year)
Project Costs:	In the academic year 1974-75, explicit costs were substantially higher than in the succeeding year, due to the intensive research component of the project. In addition to the $5,000 stipend (paid to a graduate student who served as a clinical supervisor), an estimated $22,000 was expended for research staff, including interviewers and data coders. The $5,000 stipend was the total expenditure for 1975-76. During both years, undergraduate students served as intervention agents.
Funding Source:	National Institute of Mental Health (#MN 22336)
Target Population:	Juveniles referred by the police in lieu of petition to juvenile court. The typical ADP client was a misdemeanant with two or three previous police contacts.
Project Goals:	. To provide juveniles in the neighboring communities of Urbanna and Champaign with an alternative to formal court proceedings by intervening at the point of police contact and offering counseling and social assistance; . To provide students at the University of Illinois with practical experience in social intervention techniques by involving undergraduates in the service delivery process; . To find out more about the whys of delinquency and its treatment by delivering services within the framework of a carefully controlled experimental design.

Project Operation (Overview):

For several years the University of Illinois Psychology Department had been involved in developing community services through course offerings and practicums. As a result, the ADP organization evolved from a solid base of previous experience in bringing University resources to the aid of the community. ADP, itself, was actually part of a larger research effort developed by the Community Psychology Action Center to study the effectiveness of using undergraduates as volunteer social services providers. The Community Psychology Action Center is a loosely structured faculty group within the Department of Psychology that has sponsored a number of community services and activities. Generally, the Center is a University-supported training program for both graduates and undergraduates and aims to serve the community through planning and participating in social programs and providing students "real world" experience in their course work and research. ADP intervention services were carried out by well-supervised university undergraduates who were expected to spend 6-8 hours a week with their clients over a period of 18 weeks.

Juveniles were referred by the police to ADP in lieu of petition to juvenile court. If a youngster and his or her parents agreed to participate, the youngster was randomly assigned to either the experimental or the control group. Student volunteers were then matched with youngsters in the experimental group -- whenever possible, by sex, race and personal interests. Members of the control group received no intervention services and were released to the community.

The youngster and assigned volunteer typically spent several weeks getting to know one another. Once the two had established a relationship, the volunteer assessed the needs and problems of the client, and, with the help of peers and supervisors, developed a program using one or a combination of techniques known as behavioral contracting and child advocacy. Volunteers using behavioral contracting would monitor and mediate written contractual agreements between the youth and the parents concerning real-life issues such as: privileges to be available to the child in return for complying with curfews, house chores, and personal appearance. Contracts with teachers were also frequently drawn up. The principle of a behavioral contract is that clearly detailed responsibilities must be fulfilled by the youngster as well as by the other participants in the contract.

The volunteers, using child advocacy, would personally act to secure the rights of their clients when the clients faced crises, such as suspension from school. Moreover, the advocate would introduce the child to available educational, welfare, health, mental health, and vocational resources that could be used on the child's behalf. In each of the intervention strategies, the students attempted to ensure that their clients could serve as their own monitors and advocates after the students' involvement in the project had ended.

A unique aspect of this project was the use of the educational pyramid, an innovative paradigm for training and research in the community psychology (Seidman and Rappaport, 1974). As a model, the educational pyramid provides a means for understanding and evaluating the impact of community interventions

at multiple levels of society, and a means for rigorous and systematic evaluation of human service programs. It is also extremely valuable for training future professionals and non-professionals in specific career goals. The model combines use of graduate students in program administration and training roles with undergraduates or other non-professionals (e.g., senior citizens, community volunteers) who serve as workers. The pyramid is usually headed by an experienced psychologist or professional person who acts as teacher and supervisor.

Project Operation (Innovative Aspects):

Behavioral Contracting

In sum, the behavioral contracting model involved the following activities on the part of the student intervention agent:

- During the first two weeks of contact, the student attempted to build rapport with the youth and began to assess areas of interpersonal conflict. Attention was focused on the home and school and on selection of behaviors to be modified and critical persons to be involved.

- The following week the student involved the youth and those persons with whom he or she had a "dysfunctional relationship" in a process of specifying the behaviors or attitudes each would like changed.

- Sometime near the fourth week, the student "negotiated" the written agreement between the parties. The contract specified what each person would change in the relationship and what each could expect.

- Throughout the intervention, the student functioned as a mediator, assisted in the renegotiation of the contract, as necessary, and helped the parties achieve satisfactory results from the process.

- Approximately four weeks prior to termination, the student attempted to instruct the youth and other persons involved in the contract in how to maintain an ongoing process of behavioral contracting. After instruction and sufficient practice, student involvement was terminated.

Child Advocacy

The child advocacy model for ADP involved the following activities on the part of the student intervention agent:

- During the first two weeks of contact, the student attempted to get to know the individual youth and began to determine with the youth the problem areas and targets for change.

- The student became involved in manipulating resources for the youth, applying a variety of advocacy strategies.

- Sometime around the third month of intervention the student instructed and encouraged the youth to initiate his or her own advocacy actions.

- During the last month of the intervention, the student prepared the youth further for his or her own advocacy role and for the termination of formal intervention by the student. The student assumed a passive role, limited to consulting the youth while the youth carried out his or her own advocacy efforts.

Results/Recommendations:

The Adolescent Diversion Project succeeded in three important areas:

1. Reducing the number and severity of police contacts during and after the intervention period. The experimental group fared significantly better than the control group in 1973-74. Similar results were found in comparing the combined experimental group and the control group in 1974-75. In this latter year, however, no significant differences were found between the behavioral contracting and the child advocacy approaches within the experimental group.

2. Reducing the number and severity of court petitions filed during and after the intervention period. The experimental group again performed better than the control group in both years.

3. Improving school attendance. All youngsters were enrolled in school at the time of their referral to ADP. In the second year at termination, 71 percent of the combined experimental group was still enrolled, in contrast to only 50 percent of the control group.

Why did ADP succeed in curbing delinquency? While there are a number of hypotheses, the answer is not clear. ADP researchers undertook an exploratory survey of the intervention process and studied the psychological impacts of intervention, but the measures used are only suggestive of specific causes of the favorable outcomes.

The Adolescent Diversion Project has clearly achieved a part of its goals: it has been able to construct and operate two distinct treatment modes which result in significantly fewer legal contacts than does the comparison procedure of no service at all. The goals of distinguishing between the effects of the two contrasting models, or explaining the mechanism through which treatment effects change in subject behavior, were more elusive. Furthermore, the question remains whether the role of a sympathetic and helping figure in the youth's

life may have created any positive changes rather than the student's application of a specific counseling technique.

Thus, the task for those who would replicate the ADP concept is not to emulate any single aspect of the Illinois experience, but to continue to explore the effects and consequences of intervention by applying academic resources to the pursuit of service-oriented research.

For More Information:

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Department of Psychology
University of Illinois
Champaign, Illinois 61820
(217/333-8156)

Project Name:	The Attention Homes
Project Location:	Boulder, Colorado
Recipient Agency/Organization:	Attention, Inc.
Project Duration:	1966 - present
Project Costs:	Approximately $',500 per year per house
Funding Source:	Boulder's Attention Home is financed entirely by community donations. It does not depend on Federal or State funds, nor is it included in the United Way or Community Chest Programs. Cash expenditures for Attention Home Number 1 were $',310 during its first year of operation in which it served an average daily population of between five and seven children. A nonprofit tax-exempt, organization called "Attention, Inc." was formed by several members of the adult study class of the First Methodist Church, representatives of the court, and interested citizens in the community. Next, a proposal was made to the first Methodist Church to use their old parsonage, which at the time was used only on Sunday mornings for church classes. The proposal gained the general support and approval of the church, and its board, and it was resolved that the project should be supported by the total community. It was further agreed that a maximum utilization of the community be made in terms of financial and human services available for citizens. No request would be made of the local, Federal, or State Government for support. In whatever form local help might come - money, goods, or services - the support of the people was valued most.
Target Population:	The program was designed to serve: children with family and school problems of a personal nature, such as problems within the family sufficiently severe to erupt into open conflict; or those children whose personal adjustment in

the school or community was sufficiently inadequate as to require temporary removal of the child from the area of conflict into a less stressful setting, where treatment could be planned to occur. Often, but not always, these were children whose troubles led to behavior which necessitated their adjudication as juvenile delinquents.

Project Goals:

- To provide a group foster home for children in need of such a placement.
- To assist children in improving their social skills.
- To partially alleviate the need to institutionalize adjudicated juvenile delinquents and/or pre-delinquents.
- To help juveniles learn to cope with family problems.

Project Operation (Overview):

Boulder's first Attention Home opened in October, 1966, as a temporary (up to 3 weeks) open residence for children unable for one reason or another to function adequately in their own home. Its first resident was a 17-year-old boy from a neighboring area who left home due to conflict with his mother and turned himself into the local Neighborhood Youth Corps office in Boulder. He had committed no crime, but was without food or shelter and had no funds to provide for himself. A total of 65 children passed through Attention Home No. 1 during its first year. Although the home was designed for a maximum of eight boys and girls, it was predicted that the average number at any one time would be approximately three. This proved to be an inaccurate prediction. The home was frequently filled to capacity and often extended beyond its capacity to nine or ten, for a total of 1,500 child-days its first year.

The average length of stay for each child was planned in terms of approximately 3 weeks because it was felt that within that length of time an adequate program could be worked out so that a child could be placed more permanently in a foster home or returned to his own home.

In most cases, the estimate of the breathing space needed was wrong. The average length of stay in Attention Home No. 1 in 1967, was 10 weeks. However, for a number of children the length of stay was extended considerably longer than 3 weeks because a more permanent placement was hard to find or because it looked as if problems in their home would not be resolved in a short period of time. In the case of a 17-year-old boy who came to the attention of the court, it was found that he did not have a home and as a matter of fact had been living on his own since the age of eight.

The Attention Home has been maintained with an emphasis on positive rather than negative functions. Acceptable behavior is not only encouraged but required, and each child is assigned special duties and responsibilities within the home. Children of school age are required to attend school and encouraged to participate in related activities involving the school. They may, by permission, participate in other community activities as well.

As each child comes into the home, he/she is tested and a social summary is developed concerning his/her family, social, and academic background. The tests give an indication of intellectual ability, interests, and problem areas. (For this, we have relied on a volunteer-staffed testing program developed in the juvenile court. Lacking this in other communities, an Attention Home might well find it necessary to develop some such programs of its own.) A check is also made with other agencies in order to determine if the child has already been seen by some agency in the community, and to ensure coordination of on-going efforts. As a background is developed on each child, referrals may be made for professional services not provided by the Attention Home or the court staff.

The parents of the child are, as much as possible, involved in the continued program development for the child. This is done not only as an attempt to negotiate, but also to give the parents the continued responsibility for either short or long term planning for their own child. If a suggestion comes from a source other than the parents of the child, parents are brought into the case immediately. Indeed, unless the child is under juvenile court jurisdictions, it is not only helpful, but necessary that the parents give formal approval for even the temporary placement in the Attention Home. Parental visits are encouraged but are regulated by the home. Finally, parents of adequate means continue in the responsibility of providing for the needs of the child. The cost is based on a sliding scale of the parents' ability to pay. Of the total operating expenses of the Attention Home for 1967, about $1,400 was contributed by parents of children in residence.

A juvenile officer of the court is assigned as the overall supervisor for a particular child, in the usual system of court assignment. The officer maps out a treatment program based on the individual needs of the child which may include employment in the community as well as vocational on-the-job-training.

Project Operation (Innovative Aspects):

Houseparents

It was considered essential that the houseparents chosen to live in with the children be not only able to maintain control and discipline, but also identify sufficiently with the children in order that they could encourage and facilitate a communication between themselves and each individual child. It was one of the major considerations in the selection of the houseparents and it seemed to the board that there were advantages and disadvantages in two particular directions. First, if a middle-age or older couple were selected, they would possibly be able to relate to the children on a parent-child basis having the qualities of warmth, kindness, and patience, combined with an adequate degree of discipline. These qualities are usually found in older, more mature couples who have had experience in working with children. On the other hand, since most of these children had had difficulty in relating to their own

parents, often in the same age range, it was felt that the children might see the Attention Home as just an extension of their own home where "older people" do not understand them. It was felt that perhaps someone closer to the age of the children might be able to identify with them better and give them the kind of temporary support they need. This might be particularly important in view of the fact that the children would recognize the Attention Home as part of the total program and that young energetic houseparents, not far removed from their own generation, could perhaps offset any negative attitudes toward a court-oriented program. Also, because of the proposed extensive use of volunteers as well as the attempt toward establishing innovative programs, it was considered that young persons might be more receptive to newness of ideas, more flexible in the continued encouragement of change and innovation.

Basically, of course, the choice had to be limited to available applicants willing to work for the available money, but this did not turn out to be a serious problem. As for money, $200 per month plus room and board has been paid the regular houseparent couple. Though this really makes them only partly paid people, and partly or quasi-volunteer, there have been a sufficient number of worthy candidates for the position at this salary. As for other staff, several hundred people had been, and were continuing to, work with the court on a volunteer basis. Thus, there was considerable knowledge of many of the applicants as a result of their previous involvement on a volunteer basis with the court. Inasmuch as the first Attention Home was to be in some ways a proving ground for new programs and because it was open to the possibility of being used as a training center for persons interested in various areas of service to youth, a young couple was selected as the first houseparents of Attention, Inc. Both the husband and wife had considerable background as volunteers and administrators of volunteer programs in Attention, Inc. In discussing fieldwork training, it should be mentioned that the children in the home were not in any way used as guinea pigs for research, but rather, qualified, screened applicants would be permitted to perform volunteer services in the home under careful supervision. In choosing the younger couple, the board was completely aware of the possibility that they might indeed lack experience in working with children and that perhaps over-identification and naivete as possible negative factors would have to be overcome.

The second Boulder Attention Home, recently opened, was conceived of as a longer-range residence along more traditional lines, hence an older parental-type couple in their forties, was hired for this home.

Financing/Referrals

Attention Home is totally supported locally: the services, the facilities, the materials, and the finances, but especially the people. Secondly, this bootstrap operation is run almost entirely outside any formal agency setting such as Welfare or United Fund. It does have close cooperative relations with the juvenile court. Its referrals are almost entirely from the court, and this, too, is a new pattern -- a court having its "own" group foster home. But the Attention Home is distinct from the court. For example, of 18 people on its Board of Directors, only two are court people. Relations with professional agencies and professional people other than the court are maintained at a maximum of cordiality, but Attention Home is predominantly a citizen supported and

citizen-run organization. Those most centrally involved are laymen-highly intelligent, deeply concerned, willing to learn, but laymen nevertheless.

Results/Recommendations:

Disadvantages - Because of the more democratic structure of the Attention Home Program in Boulder County, there is a broader policy participation by the community, as represented by a Board of Directors and in other ways. This often tends to lead to less clearly defined goals and purposes and sometimes may result in a less structured organization. Under an authoritarian setting, it is not necessary to take the time to explain procedures and policies in detail, but when working with a board representing the community, it is not only helpful, but necessary to be involved in lengthy discussions often concerning incidental details which are given undue attention.

In the area of financing, it is obviously more a "nickel-and-dime" approach, requiring broad community support. This runs the risk of a minimum of support. It further requires that a large amount of time be spent on fund raising, and may make growth and expansion less possible (though Boulder's program growth has been anything but retarded). The board is undoubtedly tempted from time to time, to seek a few of the more wealthy who might be able to make sizable contributions, but has definitely not emphasized this method in order to secure a broader spectrum of support within the total community. This may run the risk of extinction if the community becomes disinterested in the home. Moreover, if potentially embarrassing problems develop in the home, community censure could well be disastrous to the organization. Also, the independence of the Attention Home from local United Fund activities -- in some respects a potential advantage -- could nevertheless cause antagonism in the community power structure as well as run the risk of securing more limited resources from those persons who felt that they had contributed their share to the community through the United Fund Drive.

A problem often found in communities is the lack of total cooperation among service agencies. The establishment of a program similar to the Attention Home might be critized as an attempt to take over the functions of other agencies. The Welfare Department or Mental Health Clinic may feel that providing such services as housing and treatment fall in their jurisdictions and that untrained or paraprofessional people have no business working with problem children. It is necessary to work closely with related agencies in establishing a program of cooperation so that misunderstandings do not occur. Board representation by allied agencies is encouraged in order to secure not only cooperation but vital and necessary involvement of these agencies in program development and treatment. A recent confidential poll of Boulder social service agency professionals showed about 80 percent of them approving the court's citizen-participation approach to problem youth, as exemplified in volunteer programs in the Attention Homes.

Advantages - One of the advantages of an Attention Home type facility already discussed is in the area of broad community support. Family disorganization and its results contribute to social problems which occur not only in the home but extend to the community at large. These problems may well become so severe that solutions through community effort are required. There are not in Boulder County, and perhaps not in any county, sufficient professional

services available to deal adequately with the many problems which social disorganization produces. Properly selected, well-trained, and professionally supervised volunteers can give valuable assistance not only in the areas of juvenile delinquency and family disorganization, but toward the solution of total community problems. Attention Home is particularly significant in this regard because it offers a broad range of channels for voluntary citizen participation: service or administration for children, contributions of all kinds of materials, and funds. Moreover, the scale of contribution may range from small to large.

A second, and major advantage, is the extensive education and understanding made available by broad community support. The more citizens understand the philosophy and the problems of the court by participating in them, the more they are likely to tolerate innovative and progressive programs in court and community. The more they understand the problems, the more they are likely to become involved in working with these problems in the community. The cause of the court then becomes their own, and they become loyal supporters of those programs and policies that are meaningful to the child and his family and have a total community impact as well.

Although a program involving broad community support may need to invest more effort in raising a given amount of funds, probably less money needs to be raised in all, because volunteer support in services and materials reduces the cost per child, and makes it possible to serve more children with less money. As already indicated, Boulder County spends less than $10,000 per year, per home, which is considerably less than comparably-sized State or Federal supported group home programs.

Assuming the court is instrumental in initiating the community group home plan, the sympathetic cooperation of its community board of directors is reasonably certain. The board will normally approve of the court's programs and philosophy; otherwise, they would not have associated themselves with the court in the first place, or remain associated in such a demanding enterprise. The group home can become a routinely functioning resource for the court and sufficient general control by the court can be maintained. This kind of working community response to court needs, and harmonic reaction to its policies, has happened in Boulder and is now happening in Ferndale, Colorado. Probably, passive acceptance of the Attention Home idea is not enough on the part of the court. Rather, the court must lead; it must be enthusiastic if the idea is to work in terms of court-controlled referrals of children.

For communities without adequate detention facilities, an Attention Home Program can save countless jail days for those children for whom lock-up would be detrimental. Locking up a child temporarily -- jail detention as a rehabilitative method -- is, at best, questionable. Of the 1,500 child-days spent in Attention Home No. 1 during the first year, it is estimated that at least 300 would otherwise have been child-days in jail; five hundred are probably more likely. Thus, Attention Home provides a favorable physical and emotional atmosphere as an alternative to juvenile jail. In so doing, it also saves thousands of dollars for the taxpayer in jail maintenance costs. The Attention Home can be a very effective alternative to State as well as local institutions. As was the case in Boulder and Adams County, and undoubtedly may be the case in many other areas, commitment was often due primarily and simply to the lack of

viable alternatives, and resulted in a relatively high rate of commitment by the court. Good group home programs can reduce commitment rates and relieve the strain of overcrowding in State as well as local institutions, at the same time easing the burden of financial responsibility on the taxpayers. There is little doubt that the chances of a child's rehabilitation are reduced if it is necessary that he be committed to institutions which, although efficiently administered and professionally supervised, are likely to be overcrowded and unable to deal with the child on an individual basis.

For More Information:

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Project Name:	Neighborhood Youth Resources Center of Philadelphia (NYRC)
Project Location:	Philadelphia, Pennsylvania
Recipient Agency/Organization	Philadelphia Model Cities Program and Crime Prevention Association (a private social service bureau).
Project Duration:	1971-present (this review will address fiscal year 1972-73)
Project Costs:	$285,342
Funding Source:	Office of Youth Development (OYD), Department of Health, Education and Welfare
Target Population:	NYRC covers a target area of approximately 70 square blocks. It is an area characterized by high unemployment, single parent families, and gang warfare. The arrest figures for youth in North Philadelphia are twice as high as those for the city as a whole. Deaths related to gang fights are not uncommon, and even those youth not yet engaged in delinquent behavior often suffer from sub-standard learning skills, poor medical care, or live in inadequate housing arrangements. The target population is approximately 4,000 youth between the ages of 10 and 17. During 1973, the center accepted 238 youngsters into its basic service program. All of these were either Black or Puerto Rican, and most of them were male. Informal referral and social and recreational services are also provided to hundreds of other youth who come into contact with the program through the community center. The majority of youth coming to NYRC are referred by the juvenile justice system and police. Others are referred by the schools, the family, community residents, and health and social agencies. Only 3% come either through self-referral or upon the advice of a friend.

Project Goals:

The major goal of the NYRC is to "divert" inner city youth from entering the juvenile justice system by providing them with a wide range of supportive services in their community and by insuring the effective and coordinated use of these services.

In addition, the following "OYD-stated objectives" provided direction in the development of the NYRC program model:

- Provide more socially acceptable and meaningful roles for youth to reduce drop-out rates; open up job opportunities; and stimulate the process of youth involvement and participation in community life.

- Divert the youth away from the juvenile justice system into alternative programs, resulting in a reduction in the annual rate of referral to juvenile courts.

- Reduce negative labeling by providing alternative youth services in the community.

- Reduce youth-adult alienation, thereby increasing youth participation in total community activities and lowering rates of official delinquency.

The aforementioned objectives were complemented by the following objectives set out by the Philadelphia Model Cities, NYRC's original delegate agency: 1) prevent seriously "delinquent prone" youth from becoming criminals; 2) offer a wide range of well-coordinated youth supportive services at the neighborhood level; 3) ensure sustained contact and follow-up through the use of neighborhood workers; 4) provide services to younger children; 5) create new models of public-private agency coordination; 6) ensure effective citizen participation through the Model Cities system; 7) provide intensive staff development opportunities with hiring preference for residents of the Model Cities neighborhood.

Project Operation (Overview):

The Neighborhood Youth Resources Center (NYRC) began operating in the spring of 1971 -- a time when gang warfare, death, and juvenile crime and delinquency were on the rise in Philadelphia, Pennsylvania. Open 13 hours a day, the NYRC provides both direct assistance and referral to other community agencies. It concentrates on providing individual casework and follow-up services. Although the program utilizes the resources of over 190 agencies and institutions that provide services to youth, NYRC maintains close contact with each youth to ensure that the service plan is appropriate. NYRC continues to sponsor the youth during the youth's contact with one or more of the cooperating resource agencies available. The individualized casework, coupled with a well-developed resource network, makes it possible to provide an entire range of services.

Philadelphia's Neighborhood Youth Resources Center has incorporated the service delivery strategies of traditional youth serving agencies with the advocacy and system change strategies of the more recently mandated youth service bureaus. The implementation of the project, which addressed both the OYD and Model Cities objectives, resulted in a delinquency prevention strategy for broad institutional change that incorporated the interests of local neighborhood residents whose families would be affected by the program. Although many of NYRC's objectives are common to a range of youth-serving agencies, in some senses, the Philadelphia agency represents a unique program type. It contains certain features associated with youth service bureau (YSB), but does not concentrate on the basic function associated with the classic YSB -- that of providing evaluation and referral services (with no further person-to-person contact) for youth diverted from or otherwise prone to entry into the juvenile justice system. It is a youth services bureau, in the more generic sense of the term, providing extensive direct services in addition to evaluation and referral services to target area youth and their families. Although NYRC's principal focus is the youth who receives direct services (the formal "client"), there are large numbers of youth who also receive referral and short term assistance. The provision of direct services is at the heart of the NYRC program. In accepting responsibility for the youth of the area in trouble with the law or prone to delinquency, NYRC provides, directly, a greater array of services than typifies both youth services bureaus.

NYRC is open 13 hours a day, providing both direct assistance and referral to other community agencies. Its services include crisis intervention, individual casework, group work involving counseling and education assistance, and legal representation. Its intervention strategies are based on the theory that youth services should operate within the context of a community center, and in keeping with this, the NYRC also sponsors recreational and cultural programs, counseling for youths on probation, and legal education for neighborhood residents. Parents, too, can participate in the planning of their children's programs. NYRC does not attempt to remove a youth from his or her living situation in most cases, but rather offers a new means of operating within the existing community.

Project Operation (Innovative Aspects):

NYRC has attempted to be a working example of the OYD strategy which states that adult institutional and social models affect the self-identity of youth, and that these same institutions can be modified or re-aligned to improve the outcome of youth development. Some of the ways in which this strategy has been implemented include:

- NYRC is respected as a change agent, legislative and programmatic. Its day-to-day relationships with other community agencies, developing from its concern in the individual case, has promoted new developments and improvements in the service delivery capabilities of other youth servicing agents. In its efforts with public service organizations, NYRC has facilitated the achievement of a more family-oriented health care delivery approach. In its work with public educational services, it claims some success in securing educational programs more attuned to children of its neighborhood. It has helped open up more private and public recreational services.

- Youth actively participate in NYRC decision-making through an advisory committee. The committee meets once a month to assess program operations, determine future program needs and potential areas of growth, and to give sanction to service or program changes. In addition, a policy of hiring some project youngsters to serve on the center's staff has also encouraged grassroots participation in decision-making. The large representation of youth on the advisory committee is but one example of NYRC's commitment to youth involvement in the program.

- Many of the staff of NYRC grew up in the target area and may once have engaged in delinquent behavior themselves. It is believed that this makes them especially suited to understanding the problems faced by their clients, and moreover, enables them to serve as logical role models for enrollees.

- NYRC works with the entire family in solving the problems of the troubled youth.

- NYRC actively seeks employment for its enrollees and has been successful in this endeavor. This is not, however, the primary emphasis. The placement of youth in a temporary job is less important to NYRC than developing awareness in the youth of a sense of job future. Within this context, the community resource worker supervises the youth's job performance toward the goal of establishing with the youth a sense of possible careers, based on interests, work habits, and skills.

- To assist youth in coping with the school environment, NYRC provides tutoring as a remedial service for target area youth.

- The Real Experience To Alternatives in Living (REAL) program provides a year's "sabbatical" to approximately 14 youths. In this program, youths are given the opportunity to work in the community center's day care program with younger youths, take courses in colleges, seek alternative jobs, and work with other youth in the NYRC chain of services. Each youth is provided with a stipend of $100 a week to enable him to "get himself together" while providing services to other members of the NYRC community. The REAL experience provides youth with both cultural and recreational opportunities while affording them the chance to develop their own personal goals and ambitions.

- NYRC clients have access to their own lawyer and do not have to go to a defender's office. Moreover, without NYRC assistance juveniles seldom benefit from any continuity of representation. Youth are represented in all proceedings by the Project's attorney.

- While the Project has not re-aligned the juvenile justice system, it has successfully intercepted youth from police and courts either before or shortly after their initial contact with the system. This has not only lessened the burden of the law enforcement system, but affords youth more rehabilitative services.

Results/Recommendations:

There were no serious limitations with respect to the Philadelphia Neighborhood Youth Resources Center Project. The program was effective and useful, responded adequately to the neighborhood youth at risk, was cost effective, and can readily be replicated.

Much of the success of this diversion project in dealing with these youth can be illustrated by the following information:

- The average length of stay in the program ranged from 47 to 64 weeks.

- During the first 9 months of 1973, community, cultural and recreational programs had a total attendance of 389.

- From February to May, 1973, the educational component reduced target area male truancy arrests by 62%.

- During this period, felony arrests of juveniles were 75% less in the target area than in a comparable area outside it.

- In 1970, there were seven gang related deaths in the target area; since the program started there have been two.

- The NYRC was examined by an independent evaluator and, as a result, was cited as an exemplary program by LEAA for its overall effectiveness in reducing crime and improving criminal justice, its adaptability to other jurisdictions, its objective evidence of achievement and its demonstrated cost effectiveness.

In response to the requirements of its HEW grant, NYRC prepares and submits quarterly evaluation reports. Short term evaluations are handled by a project consultant on a daily basis, and client impact evaluations are conducted at intervals ranging from one month to one year. Still, NYRC does not have a comprehensive evaluation program system, and while it has indeed diverted youth from the juvenile system, there are not data available to directly link the project with the decrease in local delinquency. In addition, there were no data available about the effects of: 1) reduced negative labeling, and 2) increased interaction of delinquent, pre-delinquent, and non-delinquent enrollees. More information is also needed regarding the impact of diversion on the justice system, the role diversion plays in crime prevention, and the relative rates of success on cases diverted from the system at different stages as compared with cases subjected to varying degrees of criminalization.

For More Information:

Neighborhood Youth Resources Center
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215/978-2060

Project Name:	Project Oz
Project Location:	San Diego, California
Recipient Agency/Organization:	YMCA
Project Duration:	1970 - present
Project Costs:	Approximately $113,000 to $125,000 per year. Matching funds required; city picked up entire costs after the third year.
Funding Source:	California Council on Criminal Justice (LEAA) for grant funds; City of San Diego provided the match funds.
Target Population:	Runaway youths (both male and female) 13-17 years old are provided residential treatment, and preventative and remedial counseling are available for all "beyond control" adolescents and their families. About 60% of caseload is referred from juvenile court, probation, welfare, schools, and private agencies; about 30% are self-referrals; 10% from friends and relatives.
Project Goals:	. To effectively and economically alleviate alienation between parent and child. . To reduce the incidence of juvenile delinquency. . To prevent the family unit's breakdown. . To prevent the involvement of minimal offenders in the juvenile justice system. . To provide responsible alternatives for families and adolescents in crisis.

Project Operation (Overview):

Project Oz bases its philosophy and mode of operation on the belief that dealing with runaway youth is a family affair. The intent of the project is to divert the adolescent from entrance into the juvenile justice system due to emotional problems. This philosophy, that the family setting is the only place in which runaway problems can be resolved, undergirds all the program goals. Family cooperation is part of the agreement necessary for Project Oz to extend its services to a youth.

Project Oz is more clinically oriented than most alternative settings; the mode of interaction is less casual and more professional than most. The Project's atmosphere is much more relaxed than the family home in time of trouble, and providing a relaxed situation within which families can work on problems is a project objective.

The main strategy is to provide a place for young people who are experiencing critical, unresolved family problems to live for two weeks. Having the adolescent out of the home relieves some of the pressures on him/her and the family. Counseling in this atmosphere is considered more conducive to the family gaining perspective on its problems. Project Oz works with the family as a unit to re-establish, in a concrete way, emotional warmth and caring, and from there to develop more adequate and satisfying behaviors. Parents are contacted for initial involvement within 24 hours of the youth's arrival.

The healthy part of a youth's lifestyle is disrupted as little as possible while staying at Oz. Residents live in the same community, go to the same school, see their friends and more--if they obtain permission to leave the premises. Also, residents are required to live by basic rules of conduct. A young person is free to/has available guidance to work on his problems while maintaining some semblance of order and responsibility in his life. The Project also intervenes in a youth's involvement with the law because of his illegal "runaway" status.

Project Operation (Innovative Aspects):

This diversion project serves as a vital link in juvenile care and family services. Project Oz offers a "cooling-off" service not available at other agencies in the linkage. It receives referrals and makes referrals from and to other agencies and institutions.

The following are the specific program components afforded the adolescents, their families and the community:

- Project Oz provides residents with 6 hours of individual and 24 hours of group counseling during their two-week residence; provides crafts, tutoring, recreational and vocational events, a program to develop household maintenance abilities; referral service for foster placement, health care, education, vocational training and more.

- Project Oz provides families with 6 hours of family and 4 hours of group counseling and individual counseling as needed during a youth's residence; referral services regarding health care, legal rights, long-term counseling and more; weekly groups, special interests groups (Parent Training, Mothers Group, Family Contracts).

- Project Oz provides the following follow-up services: 6 hours individual, 6 hours of family and 8 hours of group counseling over a 4-week period and is available for crisis intervention at any time. Optional involvement is offered in on-going supportive services, public relations task force, advisory board or Project auxiliary; special interest groups. Referrals are made for health, legal and long-term counseling care.

- Project Oz provides the community with notice of its availability; a weekly group open to all local adolescents; outpatient counseling as needed; educational presentations to community groups; training presentations to other community agencies; access to special interest groups.

Results/Recommendations:

Project Oz demonstrated the following results:

1. The percentage of Project Oz youth who had further contact with the juvenile justice system was low in comparision to the control group - 7% vs. 30%.

2. Approximately 70% of Project residents were successfully returned to their homes; the vast majority of the other youths were placed with friends, relatives, or foster homes. Only a small percentage of Project youths continued to run away from home after contact with the Project.

3. Project Oz youths showed significantly positive changes in personality as measured by the California Test of Personality.

Specific considerations/recommendations for other communities interested in implementing similar projects include:

1. Staff should be highly motivated and trained in family counseling and knowledgeable of community resources.

2. Project acceptance within the community was obtained mainly through a concerted effort to involve community volunteers.

3. Staff turnover has been high, primarily because of the intensity of effort and emotional strain experienced by staff.

4. The project's services were considered deficient in providing for those youths who have had brushes with the law more serious than their mere illegal status as runaways.

For More Information:

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YMCA
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Project Name:	The Sacramento County Diversion Program
Project Location:	Sacramento, California (also implemented in Virginia Beach, Virginia and Alameda and Contra Costa Counties in California)
Recipient Agency/Organization:	Sacramento County Probation Department
Project Duration:	1970-1973 experimental phase (on-going to present)
Project Costs:	The first year grant was $92,825, the second for $120,715, and the third for $17,689. These funds provided for seven staff, training and evaluation. Progressively increasing matching funds ($25,103 for the first year) were required, with the county picking up the entire costs after the third year.
Funding Source:	California Council on Criminal Justice (LEAA) for the grant funds; Ford Foundation for the match funds.
Target Population:	Juveniles referred by the police, schools or parents for traditional "status offenses" (incorrigibility, runaway, or truancy); this target population is often referred to as Children in Need of Supervison (CHINS)
Project Goals:	. To reduce the number of "children in need of supervision" cases referred and appearing in Juvenile Courts; . To decrease the number of "children in need of supervision" requiring overnight detention; . To reduce the incidence of repeat offenders among the "children in need of supervision" target group; . To decrease the cost per case "for children in need of supervision" from that required for regular processing of cases.

Project Operation (Overview):

The Sacramento Diversion Project was designed as an experiment in order to test an alternative method of handling juveniles referred for traditional "status offenses". The intent of the project was to keep the children out of the juvenile court, keep the families' problems out of the court and still offer counseling and help to the families.

During the experimental period, the project staff (a supervisor and six counselors) handled cases on four days of the week with the regular juvenile court services intake unit handling referrals the other three days of the week. After the experimental period, a separate Diversion Unit was established. It was responsible for handling only CHINS referrals, while no other intake units were allowed to handle CHINS referrals.

When a CHINS referral was received - whether from the police, the schools, the parents or relatives - the project staff arranged a family session to discuss the problem. Every effort was made to insure that this session was held as soon as possible and most were held within the first hour or two after referral. Through the use of the family counseling technique, the project counselor sought to develop the idea that the problem was one that should be addressed by the family as a whole.

Locking up the youth as a method of solving problems was discouraged, and a return home with a commitment by all involved to work through the problem was encouraged. If the underlying emotions were too strong to permit the youth's return home immediately, an attempt was made to locate an alternative place for the youth to stay temporarily. This was a voluntary procedure which required the consent of both the parents(s) and the youth. Placements were normally made with family relatives or friends.

Families were encouraged to return for a voluntary second discussion with the counselor and depending upon the nature of the problem, for a third, fourth, or fifth session. Each counselor handled a caseload of approximately twenty families and was responsible for each case from intake through final follow-up. Normally, the maximum number of follow-up sessions was four, and they were all held within two to three months after the initial referral.

Project Operations (Innovative Aspects):

This Diversion Project approach relied primarily on the following features:

- Immediate, intensive handling of cases rather than piecemeal adjudication.
- Avoidance of compartmentalized service by the creation of a prevention and diversion unit handling cases from beginning to end.
- Spending the majority of staff time in the initial stages of the case when it is in crisis - rather than weeks or months later.
- Avoidance entirely of formal court proceedings.

. Avoidance of juvenile detention through counseling and the use of alternative placements that are both temporary and voluntary.

. Maintenance of a 24-hour, seven-days-a-week telephone crisis service.

. Closer ties with outside referral services.

Family Crisis Counseling

"Family counseling", in the sense that it was used in Sacramento and similar projects, is different than is normally understood to be family counseling. It entails and emphasizes three basic concepts: (1) counseling with the family as a unit rather than as individuals, (2) focusing on the family as a whole rather than on the individual wrongdoer, and (3) insuring that communication during the counseling sessions is basically between the family members directly rather than through the counselor as an intermediary.

1. See the family as a whole - This means not talking to the child separately and the parents separately, but seeing the child and his/her family together. The "family" includes mother and father (even if not living together), brothers, sisters and anyone else who is involved in the home or the situation, including grandparents, friends and others.

2. Focusing on the family as opposed to the child - The theory of family crisis counseling is that the acting out of one member of a family is usually a sympton of a family problem and by bringing together members of that family at a time of crisis, you have the best chance of helping the family learn better ways of handling their situation.

3. Direct communications - Direct communication minimizes the temptation to provide the family with answers to questions and to take sides with one person or another about issues affecting the family. It also helps in determining whether family members, in fact, communicate with each other.

Results/Recommendations:

The Sacramento Diversion Project demonstrated the following results:

1. The amount of time spent per case was reduced by approximately 60% from the regualr processing of cases.

2. There was an 80% reduction in the number of cases filed on informal supervision/probation or having petitions filed compared to non-project cases.

3. The number of nights spent in detention for project youths was less than 1/2 that for non-project youths.

4. Recidivism within a year of initial referral was reduced by over 14% for project youths.

The results concerning recidivism are particularly impressive. The whole delinquency literature shows less than twenty projects with some proven record of accomplishment in recidivism reduction.

Specific considerations/recommendations for other communities interested in implementing similar projects include:

1. By necessity, the caseolad size should remain manageable; recommendations are for a caseload of 20-25.

2. Staff be highly trained in family counseling and knowledgeable of community resources.

3. While the data suggests that this approach could be used successfully with more serious offenses (e.g., youth involved in burglaries exhibit characteristics similar to CHINS), the program should be limited, at least initially, to those categories of offenses with which the community will feel generally comfortable.

For More Information:

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or

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or

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Virginia Beach, Virginia 23456
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3.2.27

CHILD ABUSE & NEGLECT

Project Name:	The Family Center
Project Location:	Adams County, Colorado
Recipient Agency/Organization:	Adams County Department of Social Services (ACDSS)
Project Duration:	1974 to present
Project Costs:	The Project's first year budget was $186,000 with some $14,000 coming from community agencies as match. The total second year budget was $280,000 out of which $33,000 was carried-over from the first year, and $73,900 was contributed by the Department of Social Services and other community groups.
Funding Source:	Office of Child Development, HEW
Target Population:	Abused or neglected children and youth and children and youth in risk of being abused or neglected and their families; the community and community agencies' staffs.
Project Goals:	. To foster a multi-disciplinary approach for the prevention, detection, and treatment of child abuse. . To improve client functioning by providing responsive intake and treatment. . To demonstrate the role of a nurse as an important part of a child abuse team. . To heighten community awareness about the dynamics and treatment of child abuse and about the need to report. . To increase the knowledge and involvement of school personnel in the child abuse services system.

Project Operation (Overview):

The Adams County Department of Social Services (ACDSS) concerned about the rising incidence of child abuse, which was reported to have doubled every year since 1965, called attention to the need for improved methods of handling these cases. However, the Department plan for adding staff to more adequately cover abuse cases was dashed when a state-directed budget freeze precluded new hiring. The ACDSS, as well as other local agencies including the County Mental Health Center, the Child Advocacy Team, the Juvenile Court and the Tri-County Health Department banded together to develop a multi-agency approach to child abuse.

The Project is distinct and separately housed from ACDSS, but is responsible to the department for administration and financial management. The project staff consists of a director, medical and psychological consultants, four social workers, six lay therapists, a registered nurse, and six crisis-houseparents.

The prospective client first comes to the Center's attention through referral from one of several sources; various schools and the Department of Social Services make up the highest percentage of referrals. Neighbors, relatives, and other individuals are also important sources of referrals. The calls come to the Family Center staff member on duty for that day, who takes initial information over the phone. If the call is clearly not related to actual or potential abuse, the social worker refers the caller to an appropriate community resource.

A social worker responds to every referral of suspected abuse within 24 hours of the referral. In situations that seem to be emergencies, a home visit is made immediately; otherwise, the first contact with the family is as soon as possible. The social workers, under supervision, decide whether or not to ask a law enforcement officer to accompany them on an initial home visit; such a request, however, is rarely made. The worker's assessment consists of talking to the parents and to the child, if possible, and viewing the physical and emotional environment of the home. The project nurse gives the suspected abused child a physical examination. If the child is in imminent danger, a policeman or sheriff's deputy is called, since law enforcement officers are the only ones who can remove the child from the home up to 72 hours without a court order. However, the parents may grant voluntary custody to ACDSS temporarily to take the child to a hospital or physician for a physical examination. When it is necessary to keep the child from returning home, the social worker prepares the court report required for a hearing. In determining whether the case would be appropriate for either the Center or the Protective Services Unit, the social worker checks the State's Central Registry and the Protective Services and public assistance indexes at ACDSS for evidence of any history of abuse. People associated with the family are asked to comment and to provide background information during the assessment process. If the family needs any immediate advocacy services, arrangements are made by a Center social worker while the intake process, which usually takes two weeks, is still underway.

Referrals to the Center have averaged about 37 a month since the project began accepting cases; intakes have averaged 28 a month. The Center, according to an agreement between the agencies, now handles the first six intakes each week and the Department of Social Services handles the remainder.

Near the end of the intake process, the social worker and other staff members involved will discuss the merits of the case with the Supervisor; then, based on the discussions and the primary intake person's judgment, a report is written for the weekly Multi-disciplinary Review Team meeting. The Team makes comments and recommendations concerning the case report, usually concurring with the proposed treatment goals. Many of the cases referred and subsequently presented are not substantiated abuse, but potential abuse; however, the project and Adams County Department of Social Services are encouraged to provide ongoing intervention for this kind of situation. Over 90% of the Center's cases are transferred at this point to the Protective Services Unit of ACDSS for continuing treatment.

Project Operations (Innovative Aspects):

The major thrust of the Family Center is to provide for coordinated and efficient intake, comprehensive diagnosis, and the most appropriate service delivery. In order to accomplish these tasks, the following program activities are considered integral service components:

Intake and Initial Diagnosis

During the Project's first year, non-management staff members have spent most of their time on intake and, therefore, have developed a process for efficiently handling this work. An "on-call" system has been set up, an approach to be used for meeting the reported families and gaining their trust has been agreed upon, procedures for substantiating cases have been established, and formal, written follow-up reports to the sources that reported the cases have been initiated. When reports involve child battering, a social worker and the staff nurse make the initial home visit together. The nurse gives the child a preliminary physical examination and is responsible for any necessary medical follow-up. Transfer of cases to the ACDSS Protective Services Unit occurs after the Center social worker has completed the case evaluation and after the Multi-disciplinary Review Team has reviewed the case. The transfer procedure involves preparing the client for a change in caseworkers, sending the file to a supervisor at Protective Services, and holding a meeting attended by the Center staff member involved, the newly assigned caseworker and, if possible, the client.

Multi-disciplinary Review

The Multi-disciplinary Review Team, which serves as a mechanism for diagnostic review of Center cases, meets weekly to assess staff reports on all Center and ACDSS Protective Services' abuse intakes. The Team consists of the Assistant District Attorney and representatives of the Protective Services Unit (ACDSS), Juvenile Court, the Mental Health Center and Tri-County Health, as well as the Project's medical consultant and a member of the community. Because of the usually large number of cases reviewed each week, a procedure has been worked out whereby a staff summary is prepared before the meeting and the Team members provide additional comments and recommendations they consider necessary. The second activity of the Multi-disciplinary Review Team is to monitor the agencies in the community serving abused children to ensure that they are carrying out the case recommendations of the Team.

Treatment

In addition to individual counseling, adult clients in on-going Center caseloads may receive family counseling, marital counseling, child growth and development education, and group therapy. They may also be referred to a Parents Anonymous group, one of which is sponsored by a Family Center social worker. Individual counseling and play therapy are provided to children in the Project staff's caseload. Certain treatments and services that are provided by the Center have been made available to some abuse clients of ACDSS. Below are more detailed descriptions of some of the treatment services offered by the project:

Medical Care: The Project nurse provides medical examination of children during the Center's first contact with a family suspected of being involved in actual abuse. She/he also examines the children in the crisis nursery daily. When the Project's medical position was filled, this person provided further medical services to children in the crisis nursery and is on-call for any medical emergencies. Now the Adams County Medical Group is on-call for emergencies.

Lay Therapy: The lay therapy program matches each of six lay therapists with an abusive parent. Their job entails becoming the friend of the parent(s). The criteria used as a basis for selection of the lay therapists are the following: (1.) parenting experience; (2.) ability to be supportive and yet allow another person to be independent; (3.) have mechanisms for coping with stress; (4.) evidence of a support system; (5.) ability to separate parents' needs from those of the child; (6.) ability to work as a member of a tea : and (7.) acceptance of Project sponsorship (i.e., being part of the Adams County Department of Social Services). The families assigned to the therapists all have the abused child in the home and, in each case, the parent(s), while isolated from others, ask for and accept help.

Child Growth and Development: Eight abusing or neglecting parents are enrolled in the six-session child management class. It meets for one and one-half hours once a week and is co-directed by one Project social worker and the Project nurse. Child development from birth to six years is covered in the course of the class. Plans are for the class to be a continuing resource for the county.

Crisis Nursery: The crisis nursery, which can accommodate six children at any one time, provides food, shelter and emotional support for children from dysfunctional families. Children are accepted if they are actually abused or if they come from potential abuse situations. A parent can request voluntary temporary placement of his/her child, but the actual placement must be arranged by a Center staff person.

Results/Recommendations:

While a comprehensive program evaluation has not been conducted to date, Project staff have expressed the opinion that the crisis nursery and multi-disciplinary team review have been particularly successful aspects of the Project.

Specific considerations/recommendations for other communities interested in implementing similar projects include:

1. The role of the Multi-disciplinary Team must be clearly defined and understood by participants.

2. Establishing and maintaining working relationships among the concerned agencies requires a continuous effort on the part of a center's staff.

3. Caseload size should be limited, to the extent possible, and post-treatment service delivery should be handled by the regular Protective Service Unit in order to allow adequate plan development time by Center staff.

For More Information:

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Denver, Colorado
(303) 426-0976

Project Name:	Family Stress Center (FSC)
Project Location:	Chula Vista, California (San Diego County)
Recipient Agency/Organization:	San Diego YMCA
Project Duration:	1975 - present
Project Costs:	$35,000 per year
Funding Source:	Funding was secured from the National Center on Child Abuse and Neglect (#90-C-406) and from individual donations. Additional space for the project was donated by the San Diego branch of the Salvation Army. A subcontract was also arranged for the County of San Diego to assign three full-time counselors and one full-time day care supervisor to the Family Stress Center.
Target Population:	Families where child abuse and/or neglect has occurred or where there is a high potential; families are referred from many different agencies including the police, probation departments, welfare departments, and juvenile courts.
Project Goals:	•To promote optimal development and self-actualization of both the child and the parents. •To educate parents to cope with stressful situations, through an approach known as positive parenting. •To educate the public to become more aware of the signs of family breakdown and its ramifications.

Project Operation (Overview):

The treatment philosophies upon which the YMCA Family Stress Center (FSC) is based include the following assumptions: that children have a right to their natural heritage; that all children are of equal worth - entitled by birth to develop their potential fully; that all children and families are entitled to participate in the total social and economic resources available; that punishment serves no benefit for either children or parents; that the medical-pathological model serves no useful purpose with people in crisis and is limited in the treatment of abuse and neglect; that voluntary, rather than coercive, services are the treatment of choice; and finally, that no matter what the causal factors, people can change and when given the opportunity will make choices that reflect the value premises of optimal development and self-actualization.

The facility (offices) is located in a community (Chula Vista, CA) with easy access to public transportation as well as an outreach capability. In addition, YMCA space throughout San Diego County is utilized for counseling and classes coordinated by FSC staff. The staff is highly trained in the multi-faceted complexities and issues of abuse and neglect and, further, are sensitive and able to suspend moral judgments.

The components of this project are tied together by a 24-hour, 7-days-per-week, on-call emergency response system. Treatment workers rotate on a beeper system and are available to talk to and/or go out on emergencies to homes. All calls are logged and immediate services arranged on-the-spot or by the following morning as needed. A major focus of the treatment approach is remedial and educative - with clients, other professionals, and the community.

The major treatment components utilized at the Center are the following:

Positive Parenting - A six-to ten-week training program in which hundreds of parents have participated. The design of the training is a participatory model which addresses parental styles, concepts of discipline, needs of parents and children, role reversal, the concept of empathy, parental openness, problem solving models, and communication styles. Held at YMCA's all over San Diego County as well as at FSC.

Parent Aides - Well-trained volunteers available four to ten hours weekly to visit in the home providing nurturance, support, skill training, friendship and modeling for various family members.

Emergency Caretakers - Well-trained para-professionals on-call 24 hours a day, 7 days per week, to provide emergency and respite care to families in crisis. Also used as part-time homemakers/trainers to improve parental skills, protect children, and minimize the removal of children from their families. Caretakers also are licensed as foster homes and can take children in for temporary time periods.

Child Care Center - Designed to provide high-quality child care and permit a respite, or time out, for parents on an interim basis. Center space is donated by Salvation Army, but staffed and managed by FSC. Operates from 9 a.m. to 5 p.m. weekdays. Nurse practitioner gives physicals, and Denver Developmental tests.

Individual and Family Counseling - Provided for family members when indicated and likely to be useful. The design of the treatment approach emphasizes the strengths of the individual family members and the dynamics of the family group in a growth and learning-oriented approach rather than on a pathological/historical model.

Pre-and Post-Partum Parents Group - A group for parents conducted by a pediatric nurse wherein the issues of child development are presented and discussed. Parents attended sessions with infants.

Mothers' Group Therapy - A weekly gathering for mothers to share and socialize; conducted by two professional staff members.

Babysitting - Provided either in home, at Day Care Center or at a site of FSC class or group (available during all offered services).

Advocacy - Provided by the primary treatment worker on behalf of parents and children with other social agencies, the courts, hospitals, and medical practitioners. This is a collaborative model where the treatment workers have already begun to work with other involved agencies and make themselves available for court testimony, written reports, and case management and consultation. Every effort is made to have clients review reports and records as part of the treatment process.

Transportation - Provided for family members when needed for appointments, child care, and other needs in accord with staff availability.

Psychological Testing - Administered by staff person or by psychologist with YMCA's Human Development Department.

Children's Group Therapy - For latency age children and adolescents. Also a weekly children's workshop with parents at the Day Care Center.

Parents Anonymous Groups - FSC assists in forming new self-help groups.

Training and Public Awareness - FSC staff are available to offer training and consultation to other agencies, professionals, and para-professionals. In addition, many speeches and demonstrations are held with school classes, PTA's, and Service Clubs, among others.

Resource Center - FSC maintains a large lending library of books, articles, and films, all available to be "checked out" by the public.

Project Operation (Innovative Aspects):

Drop-In Center

The FSC Drop-In Center is a combination respite and crisis center for children from families with problems related to abuse and/or neglect. As a result, the clientele served is a special one with needs that often differ from those of children in a regular day care program. The primary goals of this program are to: provide respite care for children whose parents have nothing to relieve them from the endless duties of child-rearing; provide crisis care during emergencies; provide physical evaluations and, when necessary, medical care and referrals; provide opportunities for the children to develop positive relationships with adults and peers; provide an opportunity to experience structure and consistency; provide stimulation of both a mental and physical nature; and, provide an opportunity to grasp the basic elements of socialization so that the children have a basis from which to grow and relate to others in the future.

The goals of the Drop-In Center are being met in a variety of ways. Medical needs are met by a treatment counselor who is also a pediatric nurse practitioner. He administers physical examinations to the children and makes physican referrals when appropriate. In addition, he gives Denver Developmental Screening Tests to ascertain the developmental progress of the children. Sensory motor stimulation is provided by guided play with a variety of specialized toys designed specifically for this purpose. At the same time, mental stimulation is encouraged by participation in art and music exercises and by informal education relating to reading, printing, and the use of numbers. Structure is assured by the establishment of specific times for lunch and naps. Training of staff is on-going and takes place in the day care facility. It emphasizes the need for consistency, fairness, and a genuinely positive attitude toward the children since these are elements commonly lacking in their homes.

Day care was not a major issue at the initial conception of the Family Stress Center but time has proven it to be an essential component of the treatment process. Children need a break from unhealthy home situations if they are to resolve the conflicts related to those situations and, just as importantly, parents need time away from their children if they are to effectively integrate and utilize the insights they gain from counseling.

Results/Recommendations:

The effectiveness of the FSC holistic approach to treating and preventing child abuse and neglect is currently being evaluated by E. H. White and Company of San Francisco, California. Although the findings and recommendations have not been published as yet, social theorists have explored the benefits of utilizing a comprehensive treatment modality that examines the entire scope of the family's circimstances, not simply the isolated incident that precipitated the initiation of therapy. Gill (1970, 1973) suggests that our social policies are responsible for child abuse and recommends that the solutions to this problem are political and not technical. This particular philosophy often leaves counselors and treatment workers feeling impotent and angry. The treatment approaches adopted by FSC take into account the causal relationship of social policy systems to child abuse and neglect and further provide an action plan, a method of treatment in which counselors can participate with their clients in a treatment plan that is likely to be helpful.

For More Information:

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or
Linda Walker, Treatment Director
Family Stress Center
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714/425-5322

Project Name:	Project Protection
Project Location:	Montgomery County, Maryland
Recipient Agency/Organization:	Montgomery County Public Schools
Project Duration:	1974 - present
Project Costs:	Unknown (this information can be obtained either by contacting the school system or the funding source).
Funding Source:	Department of Health, Education and Welfare, Office of Education (Title III of the Elementary and Secondary Education Act)
Target Population:	All abused and/or neglected children in the Montgomery County School System
Project Goals:	. To identify and help abused and/or neglected children and their families. . To train all school staff to recognize child abuse and neglect victims. . To make school staff aware of their obligation to report child abuse and neglect cases. . To develop a curriculum which will teach future parents how to better understand and handle their own children.

Project Operation (Overview):

The schools are in a unique position to identify and to help abused and neglected children and their families. In school, a child's appearance and behavior are observed regularly by a number of people - among them the classroom teacher, school nurse, guidance counselor and principal. If these people are trained to recognize the characteristics of abuse and neglect and know how to report their suspicions to the proper authorities, they can make an important contribution to a community's effort to combat child abuse and neglect.

Montgomery County's 135,000 school-age children attend 202 public and 60 nonpublic schools, where they are seen regularly by more than 7,000 teachers. A major objective of Project Protection, as its name implies, is to afford maximum protection to these children by assuring that all school staff members: are trained to recognize child abuse and neglect, are aware of their obligations to report it, and know the procedures for doing so. They are also working toward prevention of the phenomenon by developing curriculum units which will help teach future parents how to better understand and handle their own children.

Project Protection involves three phases: policy revision, staff development and curriculum development. Under the first of these phases, the school district's Policy Statement on Child Abuse and Child Neglect, first adopted in 1973, was revised and adopted by the school board. The new statement requires that all school employees - including classroom teachers, principals, school health nurses and health aides, speech clinicians, guidance counselors, psychologists and social workers-refer to proper authorities all children whom they suspect may be abused or neglected. This provision conforms with 1974 amendments to the Maryland Child Abuse Statute.

The policy statement defines an abused child as any child under age 18 who:"a) has sustained physical injury as a result of cruel or inhumane treatment or as a result of malicious acts by his parent or any other person responsible for his care or supervision; b) has been sexually molested or exploited, whether or not he has sustained physical injury, by his parent or any other person responsible for his care or supervision." The statement points out that an employee does not necessarily have to observe any external physical signs of injury to the child to report. "It is sufficient merely to presume that abuse has occurred when a child complains of having been sexually molested or of pain, which he says has resulted from an inflicted injury. In such cases, the report should be made."

According to State guidelines, a neglected child may be malnourished, ill-clad and dirty; unattended; ill and lacking essential medical care; exploited and overworked; emotionally disturbed due to friction in the home; neglected emotionally by being denied "normal experiences that produce feelings of being loved", and exposure to unwholesome and demoralizing circumstances.

The statement emphasizes that any doubt about reporting a suspected situation should be resolved in favor of the child.

One of the few such school policies in the nation, it also describes the procedures for reporting, explains that immunity from any civil or criminal liability is granted, and includes a sample of the county child abuse and

neglect reporting form. Copies of the statement were sent to every school staff member and distributed widely in the community and to other school systems.

Developing a system-wide policy is an excellent first step for any school system to take to focus on child abuse and neglect. Such a policy should be designed for a system's particular needs and laws and then adopted by the school board. Once a school system has determined what it can and will do about child abuse and neglect, program design can follow naturally.

Project Operation (Innovative Aspects):

Staff development, the largest phase of the project, was conducted on three levels and across several disciplines. At the beginning of the current school year, a one-day conference was held to discuss the early identification of high-risk children and to explain the Maryland Child Abuse Statute and county policies and procedures to all public school administrative and supervisory staff. About 500 people, including representatives from county health and social service agencies, nonpublic schools and neighboring school districts, attended.

Immediately following that conference, school pupil services staff, psychologists, social workers, pupil personnel workers and counselors attended an intensive two-day training workshop designed to prepare them to conduct staff development programs in individual schools.

Techniques for identifying abused and neglected children were described, the county supervisor of protective services explained what happens after a report is made and the county child abuse coordinator discussed the work of the county Child Protection Team. Other discussions focused on the psychodynamics of abusing and neglecting families, working with abused and neglected children and their families and sexual abuse of children.

Representatives from county departments and nonpublic schools also attended the workshop, and all 125 participants received a detailed information packet and a bibliography of the child abuse materials available in the school system's professional library.

In the third phase of staff development, members of pupil services staff conducted training programs during regularly scheduled faculty meetings in all public schools in the county. A model presentation was designed and adapted to fit the needs of the school served, for the purposes of: helping staff members recognize child abuse and neglect; making them aware of their responsibility to report and the immunities provided; and informing them of the proper referral procedures.

About 15 percent of the school-age children in Montgomery County attend nonpublic schools. To reach this group, Project Protection distributed information on child abuse and neglect to each school, and staff development programs have been conducted in many of them. In cooperation with Project Protection, a social work field unit from Catholic University of America provides direct service, focusing on early detection and prevention in nine nonpublic schools.

Curriculum Development

Curriculum development addresses the subject of prevention. This phase of the project applies information about the underlying causes of child abuse and neglect to teaching units designed to better prepare students for parenthood. Existing curricula has been expanded and new units developed around four basic themes.

- Nutrition Growth and Development and the Maltreated Child. Characteristics common among abusing or neglectful parents include a lack of nurturing in their own childhood and an ignorance of a child's normal developmental stages. These often result in unrealistic expectations for the child. Teaching units emphasize the importance of nurturing and the "nurturing imprint" in infancy, and give increased attention to acquainting future parents with the normal developmental stages of early childhood.

- Violence in Society and the Maltreated Child. The tendancy of maltreated children to become abusing parents or to commit other antisocial acts is frequently cited. Thus, teaching units address the relationship between violence in society and violence against children.

- Stress in the Individual and the Maltreated Child. Inability to cope with stress is often cited as one of the major factors contributing to the maltreatment of children. The importance of recognizing and coping with stress, whether it originates from within or outside the family structure is emphasized in this teaching unit.

- Child Protection and the Maltreated Child. In conjunction with the the three areas of emphasis mentioned above, a teaching unit on child protection itself has been developed. This includes a history of child protection, a discussion of the maltreated child syndrome, and an introduction to community resources for the maltreated child and his family.

Results/Recommendations:

Students themselves have indicated that they want to learn more about the maltreatment of children. During the past year, for example, child development, human development, sociology and psychology students at many area high schools have chosen related aspects of child abuse and neglect for class projects. Many believe that a curriculum unit on "How to be a Parent" should be required for all high school students. Although, traditionally, girls have been taught some parenting skills in home economics or other classes, they represent only 50 percent of the parent population. Courses on parenthood should be offered to all students and the courses should emphasize how important nurturing-or the lack of it-is to a child's normal growth and development.

Ultimately, the success of any school program in the area of child abuse depends upon those who are in daily contact with the children. If staff members are familiar with the maltreatment syndrome and can recognize the signals of a child at risk; if they know they must report suspected abuse and neglect, and that they have legal immunity when they do so; if they are familiar with

required referral procedures; and if they are convinced that their referrals will be handled promptly and intelligently; they will become a vital force in the detection and prevention of child abuse and neglect.

For More Information:

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Rockville, Maryland 20850
(301) 279-3000

Project Name:	Suspected Child Abuse and Neglect (SCAN)
Project Location:	Little Rock, Arkansas
Recipient Agency/Organization:	SCAN Volunteer Services, Inc.
Project Duration:	1974-present
Funding Source:	Office of Child Development, HEW; (Demonstration Grant)
Target Population:	Abused or neglected children and youth and children and youth in risk of being abused or neglected, and their families; the community and community agencies' staff.
Project Goals:	. To demonstrate the feasibility of the volunteer model, in which lay therapists provide protective services for children and youth. . To identify, develop, expand, contract for and coordinate county-wide resources for more effective SCAN/Social Services Operations. . To ensure immediate delivery of services to protect clients and to encourage other agencies to accept and provide services to Project clients. . To educate the community, including professionals, about the dynamics of abuse and the necessity of reporting as required by law.

Project Operation (Overview):

The SCAN Project was designed to centralize child abuse and neglect reporting within a community and to increase the staff resources available within a community that can be devoted to the investigation of abuse or neglect reports. This increases the likelihood for all reports to be evaluated in the families' homes and periodic follow-up after a case is stabilized.

While Arkansas Social Services is ultimately accountable to the State for providing protective services, it can, through contract, delegate duties for child abuse cases (e.g., to SCAN). A local Social Services Coordinator (a staff member of the local Social Services division) plays the dual role of speeding up the provision of services to SCAN clients who are receiving social services from the agency and of ensuring that reported child abuse cases get the attention legally required by the State.

Almost all referrals to the Project come by telephone, from other agencies in the community, particularly Social Services and the Juvenile Court, and from neighbors, relatives, anonymous callers and self-referrals. For all reports, the SCAN Director calls the Social Services Coordinator to find out anything that Social Services may have in their records about the case and then prepares for the home evaluation. At this time, a report is sent to the Central Registry.

All cases are evaluated by the local SCAN staff within 48 hours, but crisis cases are evaluated immediately, regardless of the time of day or night. During the evaluation, the SCAN Director takes a non-threatening position with the family, offering help and trying to get the family to accept SCAN services. If there is any reason to suspect that abuse might have, or potentially, occurred a lay therapist will be assigned and begin visiting the client at once. If the initial evaluation indicates that the case is a neglect case, it is reported to Social Services and referred to the appropriate agency.

Once the evaluation has shown that there has been abuse or severe neglect, or that there is potential for it, the case is entered in the SCAN caseload and begins to be reviewed at the bi-weekly SCAN staffing sessions. A preliminary case plan is made by the local SCAN Director and the lay therapist, with assistance from the State SCAN Coordinator and the Social Services Coordinator in some (i.e., severe) cases, to provide immediate services beyond the lay therapy, such as day care or counseling, which need to be arranged through Social Services. Besides the reviews at SCAN staffings, the case will be reviewed by a multi-disciplinary team if it is a hospital case or a particularly serious case, and possibly by the community consultation team in the counties that have one. The progress of treatment is subsequently reviewed as needed.

The main service offered by the Arkansas Project is lay therapy, which takes place during visits to the client's home. Depending on the severity of the case or the degree to which it is stabilizing, the intensity of the lay therapy counseling provided may vary widely. Typically, a relatively new, difficult case receives considerably more then the average

six hours of lay therapy counseling per month. In general, the lay therapists strive for some form of weekly contact with their clients. In addition, clients may receive individual counseling or participation in Parents Anonymous.

As a case stabilizes, which may be six months or more after the initial referral, the intensity of lay therapy will normally taper off from several visits a week to a much lower frequency. The project continues to maintain contact with the client indefinitely and keeps the client's file open, though in a stabilized status. The case continues to be mentioned from time to time during staffing sessions and during the diagnostic review team meetings. In this way, SCAN is in a position to resume more intensive treatment as soon as there are signs of need for it. If an unstabilized client moves from the county or State, the case is referred to the appropriate agencies.

Project Operations (Innovative Aspects):

The SCAN project approach relies primarily on the following two features: education and lay therapy.

Education

The project provides public education, professional education and training for the lay therapists. The public education provided by the local projects takes place mostly in the form of various kinds of speaking engagements with schools, community groups, and other groups in the county.

An integral part of the operation of SCAN is the recruitment and training of lay therapists. The lay therapy training session in Little Rock runs for three times a year and are generally scheduled to accommodate the volunteers who are waiting to begin. In the second year of the project, the SCAN training sessions are open to other members of the community besides lay therapists.

After the initial training session, the lay therapists continue to receive training in the form of the guidance given them during the bi-weekly training sessions, and also attendance at special seminars on selected topics several times a year.

Treatment

The SCAN units principally offer crisis intervention and lay therapy as treatment services. The local staffs have also organized Parents Anonymous chapters, multi-disciplinary teams, and hospital committees in the demonstration counties and provide continuous support for them. Within Parents Anonymous, they arrange for volunteers to be on hand to care for children while their parents are in the session; they provide transportation to the session when it is needed; and, above all, they provide the patient with sensitive coaxing, sometimes extended over several weeks, that is needed to get some parents to attend Parents Anonymous. Through Arkansas Social Services, the local projects also make day care and foster care services available.

Lay therapy counseling is the name given to a complex set of responsibilities. The prime task of the lay therapist is to establish a trust relationship with the client. From this basic therapeutic friendship, various hats are assumed by the lay therapist, such as that of a parenting model; marriage, sex education and/or child development counselor; as well as that of a resource and advocate for needed auxiliary services, including homemaking, babysitting, day care and transportation. In assuming any and all of these responsibilities, the lay therapist strives to maintain a non-judgmental, non-punitive relationship with his or her clients with the goal being the enablement of the parent to reach discipline alternatives to abuse and to achieve independence.

Crisis intervention is a distinct service of the Project and an integral part of the lay therapy. Sometimes a case is initiated through SCAN's intervention in a crisis situation that is reported to the Project. Once a case has been accepted by SCAN and a lay therapist is assigned, the lay therapist is "on call" to the family 24 hours a day. Follow-up, which was also originally planned as a distinct part of the Project, is now built into the lay therapy service in the sense that cases are not closed, but rather stabilized, and the lay therapist continues to keep in touch with the family from time to time to assess its ability to function independently.

The lay therapists make themselves available for accepting cases assigned to them by the SCAN director. They sometimes participate in the initial investigation of a case during intake and then begin their lay therapy on an intensive basis when they are assigned to the case. Their hours are flexible, but they are on call to the families they are working with 24 hours a day, 7 days a week. The lay therapists are reimbursed for up to $50 of their expenses per month and are considered volunteer staff members. This reimbursement is a critical consideration in the lay therapy model, in that, depending upon the personal finanical situation of the volunteer, the $50 monthly budget may offset any disadvantages they may experience in volunteering. Turnover among the lay therapists has been very low, usually occurring only when a lay therapists moves from the community or when there is a change in the lay therapist's own family situation. Many of the lay therapists have college degrees, and some have been trained in or have worked in various professions which help them in their work and add to the effectiveness of the bi-weekly case reviews.

Results/Recommendations:

The SCAN Project, to data has not been formally evaluated. However, a recent Office of Child Development report indicates that the SCAN Project has had few serious implementation problems, but appears to be operating successfully.

Specific considerations/recommendations for other communities interested in implementing similar projects include:

1. When volunteer services are utilized, the issues of credibility and legitimacy of the non-profit agency are called into play; this requires competent staff on the part of the volunteer organization and assistance from the local social service agency.

2. The legal requirement of the clients relative to confidentialty must be addressed - agreements are needed to ensure sharing of information.

3. In order to maintain volunteer enthusiasm and participation, administrative requirements assigned to the volunteers should be held to a minimum; administration should be assigned to regular paid staff.

For More Information:

SCAN Volunteer Services, Inc.
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Little Rock, Arkansas
501/371-2773

DAY CARE

Project Name:	Amalgamated Day Care Center
Project Location:	Chicago, Illinois
Recipient Agency/Organization:	Amalgamated Clothing Workers of America (ACWC)
Project Duration:	1970 - present
Project Costs:	Amalgamated Social Benefits Association $154,000 In-kind 3,900 Total $158,000

The Amalgamated Social Benefits Association is an independent trust, established through a collective bargaining agreement between ACWA and the employees of the garment industry. The employees supply a certain amount of money equal to a percentage of the monthly payroll; consequently, the amount varies from factory to factory. The union then uses this money to provide services to its members. (cost figures are for the calendar year 1971)

Target Population: Preschool-age children whose mother and/or father belong to the union.

Project Goals:

- For children - planned skill teaching in self-reliance, self-image enrichment, peer cooperation, health and nutrition, cross-cultural appreciation.
- For staff - advancement through training and in-service support.
- For parents - lessened financial strain, knowledge of adequate care for child, less absenteeism, health care and social service assistance otherwise not available.

- For employers - increased productivity and efficiency, less absenteeism, more stable work force, less turnover and decreased tension in the factory during working hours.

- For union - greater unity of organization; opportunity for meaningful service to union members who are parents of children three to five years of age.

Project Operation (Overview):

The Amalgamated Day Care Center is located on Chicago's West Side, in a re-emerging industrial area on the edge of a ghetto. (Additional Amalgamated day-care centers will be located much closer to the factories themselves; since there is no central residential area for them to serve, and transportation is a problem for parents.) The Center is a small one-story structure immediately adjacent to the five-story union building, which houses the Sidney Hillman Health Center, Social Benefits Association, and the ACWA retirees' center.

When the Center opened, the children, new to any kind of away-from-home situation, lacked internal controls and were unaccustomed to limits and direction in working and playing with adults and other children. The freedom of the building design intensified this chaotic situation. Movable partitions were added as an afterthought, in an attempt to alleviate the confusion. Despite some current inconveniences for the staff, the building is bright, colorful, warm, and fun for little children.

Each child has his own section of cupboards along the side walls and his own small cot stacked underneath. The tables and chairs are all child-size, as are the water fountains, sinks, and windows. The director's office is surrounded on two sides by glass so anyone can see in even when the door is shut. There is no room into which the children do not have either free access or a clear view to see what's going on. There is a playground in back of the building, and steps from it lead up to the roof of the building, which has also been made into a fenced-in play yard.

At Amalgamated Day Care Center, union operation is in itself a notable element. The fact that the Center is seen as a model for future expansion has resulted in the development of several other exemplary features, including financing, education, and health care. These features are a direct result of union sponsorship and can be duplicated only in the case of backing from an organization with similar commitment and resources.

Project Operation (Innovative Aspects):

Educational Program

Early education is a special need for children whose environment limits the amount of intellectual stimulation they get in their preschool years. In consultation with the psychologist who visits the center periodically, the staff has assessed its client children as experientially deprived and has planned a

complete educational program for them on that basis. Although all aspects of the program are interrelated, primary emphasis is placed on intellectual development, particularly on general language development. Many of the children do not speak English or speak and understand it poorly; parents have expressed particular concern about this, wanting to be sure the children are prepared to enter the public schools.

A guiding principle in the Center program is the attempt to understand the child's behavior in light of his background and family situation. Work with the parents is just beginning, but parents are gradually realizing that the people at the center are truly concerned not only with the children but also with the overall improvement of the family's lives. No attempt is made by the center, however, to gain information about individual family incomes.

There is also emphasis on developing a strong self-image in the children. Activities are designed to encourage positive, successful experiences, avoiding competitive situations that the child's experience has not prepared him for. The staff praises and encourages achievements in language, reading development, cooperative peer relations and self-reliance. At the beginning of the year, the children were rewarded with M&M candies - a controversal feature of the program with some parents-but gradually, verbal praise is substituted for the candy rewards.

One of the main areas of concern is the development of inner controls, which most of the children lack upon enrolling in the program. The child is encouraged to accept limits, controls, and directions from adults and to work with other children. There is no corporal punishment for misconduct, which often creates conflict with parents who are accustomed to responding to misconduct or conflict with physical punishment.

Strong emphasis is also placed on ethnic backgrounds. Staff selection criteria included mixed ethnic backgrounds and both male and female sexes, with considerable attention given to finding strong male-image black staff. The present staff is a successful mixture of black, white, Chicano, and Puerto Rican men and women. There are also appropriate ethnic materials for the children to use, including records, books, puzzles and dolls. Different ethnic foods are served for lunches.

All of the Center activities and experiences are supplemented by field trips. Children are taken to museums, zoos, and parks, ususally in small groups so that each child can derive a fuller experience.

Health Care

With the initiation of the day-care center, the union has now extended the comprehensive health program to include pre-school children enrolled in the Center, as well as the day-care center staff who become members of ACWA. Each child is given an examination and innoculations, and a medical record is begun. A pediatrician has been retained and visits the Center three times a week. Any serious problems are discussed with the parents and then referred to a private pedondontist but financed by the union. Drugs, eyeglasses, and any corrective measures such as braces or orthopedic shoes are also taken care of.

The nutrition program supplements the health program by providing two well-balanced meals, breakfast and a hot lunch (plus snacks), adjusted where necessary to compensate for previously deficient diets. As a further supplement to the health program, a psychiatric social worker spends one day per week at the Center and in instances of severe emotional disturbance children have been referred to other institutions, with union financing.

Results/Recommendations:

The observation team felt that that Amalgamated Day Care Center provided quality child care and educational development. In some areas, notably parent involvement and social services, the center could be doing more and undoubtedly well as it matures and expands. In other areas, excellence already exists. At the basic care level, all elements are being provided in exemplary fashion: protection, nutrition, health, tender loving care, and general stimulation of mind and body. In addition, the center, as a part of a larger comprehensive social benefits program, has a rich mixture of program elements that meet many of the developmental needs of children, staff, parents, employers and union.

The Amalgamated Day Care Center is an excellent example of quality service, directly responsive to community need, provided by the union for the benefit of its members with funds negotiated from the employers.

For More Information:

Muriel Tuteur
Amalgamated Child Day Care and Health Center
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Project Name:	Family Day Care Career Program (FDC)
Project Location:	New York, New York
Recipient Agency/Organization:	City of New York, Human Resources Administration, Community Development Agency
Project Duration:	1967 - present
Project Costs:	$2,287 per child/year (for fiscal year 1970-71)

Funding Source:

New York Department of Social Services	$5,600,000
New York State	800,000
HUD-Model Cities	150,000
In-Kind	1,612,000
Total	$8,163,000

Target Population:

- Children of low income parents; parents must either work or be in vocational schools.

Project Goals:

- For children--protection, nutrition, tender loving care, a home setting, medical referrals, skill teaching in self-reliance, communication, peer cooperation, community awareness, cross-cultural appreciation, self-image enrichment, and bilingual education.
- For career mothers--chance to work, awareness of adequate care for children, job counseling, referral to social service agencies, parent advisory role, and parent-community social events.
- For teacher mothers--opportunity for employment, companionship, positive contact with adults and community, child-care training and in-service support, and advice and support on improving their homes.

Project Operation (Overview):

The Family Day Care Career Program, commonly known as FDC, is a system of organized home care with 21 subcenters located in New York City communities, each administering 40 to 60 homes in the neighborhoods they serve. The subcenters are coordinated by a central office, which provides technical support to the centers. The central administration consists of a director, an assistant, four technical assistants, and four clerks. At each subcenter level, a director, day-care counselors and aides, educational aides and specialized consultants support the work of teacher mothers, who take children into their own homes, and career mothers, who are working and need day care.

Basic child care is accomplished in day care homes licensed for space and sanitary facilities by the city and the State. Enrollment is limited to six children in a home, including those of the teacher mother. There is often a mixture of ages and ethnic backgrounds. Children and all members of their immediate families are required to have physical examinations before entering the program; centers help with such arrangements. Parents are also responsible for taking children to and from the day care homes (usually located close to the parent's home).

Project Operation (Innovative Aspects):

Educational Program

There can be up to six children in each home, including the teacher mother's own children. Also, there can be no more than two children under two years of age in one home. Children are usually assigned to a home near them, after interviews have disclosed that the teacher mother, career mother, and children are compatible. The system's children are reported to be "normal" both mentally and physically. The centers are not equipped to handle disturbed children but may refer families needing help to appropriate agencies. The child curriculum is organized around the areas of social studies, mathematics, science, art, and music. Within these areas, specific materials are developed for different age groups.

Working with Mothers

At the start of the program, there were serious problems of allocation of responsibility for the children. The Family Day Care system doesn't have the resources or staff to combat the erosion of the parental role that often occurs. Work with teachers and others must be tactful, explicit, and continuous to ensure that these homes do not undermine the real parents, partly because many day care homes offer love and stability to children who have neither in their own homes.

Family Day Care provides focused contact with adults in many ways. A mother who inquires about the system has a choice of providing or using child care. The day care staff provide mothers with emotional support, while at the same time helping them upgrade their job performance in or out of their homes. Each center is linked to a larger network of job and social service resources, and these are used as much as possible to help those who have decided to become career mothers.

Prospective teacher mothers are carefully interviewed about their interest in child care. Their homes are inspected, and observers also note their relations with their own children. They receive early childhood training at city-wide and local center sessions before they begin placing children in homes. The staff tries to find a mother whose home is close to the child's. An effort is made to mix children with different ethnic backgrounds and in most centers, the children are not grouped by age.

Center personnel support teacher mothers in many ways. Educational aides visit the homes to help with activities and discuss problems. Day care aides check on the care given and also offer support. Center staff babysit the children when the teacher mother has medical appointments or must be out of the house for some other reason. The system provides suggested activities and materials, although the educational component is badly underfunded.

The career mothers in Family Day Care (like all parents interviewed in major child care demand surveys) place high priority on having their children close to home. Parents continually note both the convenience of not having to transport children and infants and the psychological benefit of having their children stay in the neighborhood. The Family Day Care system suggests that home care can deliver close-to-home service in a much wider range of residential areas.

Family Day Care has two career development paths internal to the program and one outside the system for career mothers. All mothers who enter the program may become either provider or career mothers; many provider mothers later become career mothers. A vocational counselor is placed at the subcenter and is responsible for working with each career mother to see that she receives testing, training, and job placement as appropriate as possible to her interests and abilities.

The system also has an internal career development program, which funnels staff upward. The system is committed to hiring from within, giving its own people, with their specialized knowledge of their communities, a chance for more responsibility and better pay.

Results/Recommendations:

It was the judgment of the observation team that the children at the Family Day Care Career Program were being cared for in warm, family atmospheres, and while the educational component was minimal due to lack of funding and equipment, teacher mothers were providing love and attention. In addition, the program represents a real step up for both career mothers and teacher mothers in allowing them to do purposeful work and earn a salary.

Due to severe underfunding, the Family Day Care Career Program of New York does not approach the perfect home care system: supervisory staff and teachers are paid very little on a per hour basis; there is not enough money

for adequate educational programs or even a minimum supply of educational materials. The FDC system has, however, surmounted these difficulties in its creation of a warm, swiftly growing, cohesive and very creative "frontier" community. Its internal personnel communications are generally a model of responsible, honest human contacts at every level. The shortcomings of the system must be seen in the light of the enormous step forward FDC represents for participants: close-to-home, and reliable child care.

For More Information:

Director, Family Day Care Career Program
240 Church Street
New York, New York 10013
(212/553-6468)

Project Name:	The Greeley Parent Child Center
Project Location:	Greeley, Colorado
Recipient Agency/Organization:	The Greeley Parent Child Center
Project Duration:	1969 - present
Project Costs:	$1,445 per child per year (fiscal year 1970-71)

Funding Source:

Welfare	$10,300
University of North Colorado	500
United Fund	2,500
State Food	5,100
Colorado Migrant Council	7,100
Monfort Meating Packing Co.	1,200
In-Kind	28,000
Total	$54,900

Target Population: Preschool migrant children who meet OEO poverty level guidelines.

Project Goals:

- For children - self image enrichment, self-reliance and determination, communication skills, peer cooperation, health and nutrition, and cross-cultural appreciation.
- For parents - chance to work, awareness of adequate care for child, community control of program, maintenance of parent role, social service referrals and other assistance, further educating, and parent community social events.
- For community - improved migrant worker - community relations, better living conditions for the migrant community, volunteer opportunities, and social service information and liaison.

Project Operation (Overview):

The Greeley Parent Child Center is a day-care program for migrant, seasonal and rural poor children and their families living in and around Greeley, Colorado. It is operated by the parents, with advice and assistance from the local community, a college, and a university. It is an effective example of parent control and community involvement functioning smoothly in a new cooperative effort between Chicano migrant, rural, and Anglo communities.

The center sees itself as far more than a baby-sitting service. The center believes that it "...Provides an atmosphere conductive to the teaching of educational and social readiness for an optimum of forty children." The educational program is carried out by the director, the head teacher, and two teacher aides. Health care is provided by a core of professional volunteers, and food service is contracted for with the public schools. Outdoor and indoor space is adequate (the building has just been remodeled by center parents), as are materials and equipment.

Project Operation (Innovative Aspects):

Education Program

The Peabody Language Kit is available for use principally by volunteers, and an exciting stimulation kit contains a series of soft cloths, bags with things inside to play with, feel, put together, puzzle over, and otherwise enjoy. The bags are packed in a brightly colored suitcase, and it is an enormously useful device for introducing a new volunteer to the children. It allows for instant use by any person who shows up without time-consuming instructions. Other materials include records, a record player, a filmstrip projector, a television set, balls, crayons, swimming pools, and a piano. Homemade materials include a rocking boat, steering wheels, blocks, a paper carton playhouse, bean sacks, noisemakers, and so on.

There are approximately 22 or 23 children in the large main floor at any one time, with 16 or 17 younger children downstairs. About 14 children come in during the morning from 8:00 A.M. to 11:00 A.M. and then go off to a Head Start Program. One teacher aide works with each group, and the head teacher divides her time. The director fills in where she can, and volunteers are incorporated as they arrive. There is an effort to plan activities that will enhance school readiness. Occasionally, small groups of children are taken on field trips.

Food

The center works to maintain a well-balanced diet for the children, providing a hot breakfast in the morning, a hot lunch, and an afternoon snack of fruit or vegetables. The food program is contracted through the local school district. One of the problems with the contract food service is that seconds are rarely available.

Health Care

The center has organized the services of several volunteers to provide health care for the children. The nurse in the local public health office sees the children regularly for about three hours a week. A local dentist is paid by a community services agency to provide free dental care. A local pediatrician spends an average of half an hour a week dealing with center children.

Results/Recommendations:

The observation team that visited the Greeley Parent Child Center in November 1970, was impressed with the day-care program provided for the center's children. At the basic care level every element was present: protection, nutrition, general stimulation of mind and body, health care, and genuine affection. Moreover, the center has a rich mixture of services designed to meet the needs of the children, parents, staff, and community-at-large.

The Greeley Parent Child Center is an excellent example of what parents and a community can do to improve the lives of their children and their families while bringing the Chicano migrant and Anglo communities together effectively. The center is serving as more than a place to care for children; it is in fact a place for parents, children, and community and could well be called the Greeley Family and Community Center.

For More Information:

Director
Greeley Parent Child Center
131 West Union Avenue
La Salle, Colorado
(303/284-5250)

Project Name:	Rural Child Care Project
Project Location:	Frankfort, Kentucky
Recipient Agency/Organization:	Kentucky Child Welfare Research Foundation, Inc.
Project Duration:	1965 - present
Project Costs:	$2,663 per child per year (for fiscal year 1969-70)

Funding Source:

Office of Economic Opportunity (OEO)	$948,200
In-Kind-Kentucky Research Foundation, Inc.	54,000
In-Kind-Other	214,900
Total	$1,217,100

Target Population: Preschool children whose parents meet OEO poverty guidelines and are accessible to Center's transportation.

Project Goals:

- For children - opportunities for basic socialization and peer cooperation, language development and self-expression, medical attention, compensatory and maintenance nutrition, and special needs.
- For staff - advancement through training and education opportunities, adequate pay, community involvement, and training in a variety of skills.
- For parents - employment, medical and social service referrals, direct help through homemaking, skills for improvement of family life, involvement in decision-making, educational benefits, basic socialization, and awareness of adequate care for children.
- For community - significant volunteer opportunities, coordination of community services and development of new services, realistic identification of needs and ways to meet them, and training of community people to become new resources.

Project Operation (Innovative Aspects):

Education

The Rural Child Care Centers try to provide a warm, understanding, and stimulating atmosphere in which economically and socially deprived children can learn cognitive skills. When the Project got underway, the para-professional staff was not qualified to develop and implement an education program, but since a good number of people have been with the program from the start, they have, over time, acquired the necessary skills and experience. The education emphasis is placed in individual expression through the use of creative materials. Both free and structured activities are included in the program, especially those that develop decision-making abilities. Unit planning is used to coordinate the week's group activities around a common theme.

The 19 centers are open from September to June, and 17 centers run a nine-week schedule during the summer. There are, generally, 30 preschool children in a center, divided into two groups of 15, according to age, maturity, and length of time in the program, and need for socialization and adult contact. Each group has a teacher (one is a senior teacher), an aide, and often several volunteers. Each center also has a cook who works directly with the children on nutrition education, a custodian (Operation Mainstream or other), and one or more transportation aides.

An effort has been made to capitalize on the children's experience and environment. A science table in each center has materials that the children have gathered: lumps of coal, wasp nests, leaves and plants. These are often labeled and discussed. Native animals (opossums, woodchucks) are drawn, identified, and sometimes kept as pets. Naming of familiar objects and verbalization in play are particularly stressed to compensate for the often limited range of the children's verbal expression.

The Rural Child Care Program has been concerned with the effect of its program on the children's progress in later school grades. So far the research on this effect has been inconclusive. The Project intends to experiment with more structured curriculum in the hope that this will strengthen its compensatory developmental effort.

Health Care

The county social worker is responsible for providing medical and dental services to the centers. When needed health care cannot be provided at the center, children are taken to local clinics and doctors. For special attention they may have to be taken farther away. All children are given physical examinations, innoculations, and other treatment as needed. In addition to providing services, the centers encourage parents to obtain services for themselves and other family members.

Project Operation (Overview):

The Rural Child Care Project operates 19 day-care centers scattered throughout nine counties in eastern Kentucky. Some of the counties are agricultural, and some of them are coal-mining areas.

Because families are scattered throughout remote areas and because funds could not be used for construction of centers, the Project has had to take any space it can get. Centers are located in churches, abandoned schoolhouses, and storefronts. Community buildings used only part-time, such as Masonic Lodges and American Legion halls have made their basements available. In other areas, the Project has obtained rooms in community center buildings, which were formerly coal commissaries, hotels, and rooming houses. The availability of outside play space differs widely from center to center. Space is limited, but it is well used. By necessity, some version of the open floor is found in most centers.

The Center deals with the simple survival needs of the children and the psychological problems common to children growing up in socially isolated and economically deprived areas. While the Project has had to make do with whatever facilities were donated by the various communities, parents, staff, and volunteers have put much effort into making them workable, cheerful, and comfortable for children. Transportation, a major problem for the center, is handled by school buses and private cars driven by hired transportation aides and volunteers.

From the beginning, even prior to its Head Start funding and guidelines concerning parental involvement, the Project employed parents and community members as its Center staff. In accordance with its commitment to community development and because of a lack of formally qualified personnel in the rural areas, all teachers are para-professionals. As a result of on-the-job training, continuing supervision, and a low turnover rate, the Project has developed an experienced and competent staff of community residents who have had little, if any, formal education.

By staffing the centers with para-professionals from the community and providing close and supportive supervision, the Project has ensured a warm, accepting atmosphere for its children. Staff and children speak each other's language. Moreover, there are usually several volunteers in attendance on any given day, increasing the adult/child ratio and the variety of adult contact. The Kentucky Rural Child Care Project is making a wholehearted effort to serve the greater community through preschool children. It has done so with a great measure of success, even though the needs of that community have, at times, appeared overwhelming.

Transportation

Transportation is an enormous problem in this mountainous area, and a good portion of the Project's budget is spent on this service. Centers solve this problem by using school buses, transportation aides, and, occasionally, contracted taxi service. Obtaining adequate insurance coverage has also been a problem.

Transportation aides are more than chauffeurs. They are a communication channel between home and center. They meet the parents, see the homes, and learn something about the child's environment and his relationship with his parents in the course of picking up and delivering. They communicate all this to the teacher to help her better understand the child. Most work four hours a day, and many elect to spend time helping out in the centers, thus easing the child's transition to and from his home.

Results/Recommendations:

Problems of the Rural Child Care Project centers have been many. The most persistent one has been finding facilities that could be adequately renovated and maintained at a minimum cost over a period of time. In order not to compromise any of the Kentucky statutes regarding day-care services, all Project centers meet all requirements for fire, sanitation, health, and space necessary to obtain a license to operate.

Transportation is another major problem faced by the Project centers. This is due to the extreme isolation so common to Appalachian Kentucky. The centers have had considerable problems in bringing in the most isolated children to the area where the centers are located. The hard winters of Eastern Kentucky with their floods and snows only add to the problem of transportation, which is bad enough when the weather is good.

With the consistent cutback in funding during the last three and a half years, there have been fewer academically trained staff giving support, supervision, and on-going training than is desirable. With the increased burden of meeting these gaps in services in the Social Service, Homemaking, and Child Development programs, staff has had to re-define practically all employee roles and responsibilities as they relate to these components to accomplish more. One of the conditions of this year's funding grant has caused considerable concern due to the instructions to serve even more children in the centers and to give participation and involvement to the parents in the target areas. This is to be carried out despite the 8-10 percent budget cut.

In the opinion of a study team, the Rural Child Care Project is meeting the basic needs of children and parents by providing a wide variety of essential services, despite geographical drawbacks and underfunding.

Most aspects of the Kentucky Rural Child Care Project are not innovations. They can be found in various programs around the country. What is exceptional here, above all else, is the engagement and activity the project has generated despite economic and topographical problems and a heretofore passive and isolated rural population.

For More Information:

Director
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Frankfort, Kentucky 40601
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CHILD HEALTH CARE

Project Name:	The Children and Youth Program
Project Location:	Charlottesville, Albemarle, Louisa and Greene Counties, Virginia
Recipient Agency/Organization:	University of Virginia Hospital
Project Duration:	1967 - present
Project Costs:	$834,515 (for fiscal year 1977)
Funding Source:	The Project is funded through the Virginia Department of Health under Title V of the Social Security Act. In addition, revenue is raised through third party payments.
Target Population:	Indigent children, birth through 21 years of age, in Charlottesville, Albemarle, Louisa, and Greene Counties.
Project Goals:	To provide comprehensive health care for the indigent population of the area, birth through 21 years of age.

Project Operation (Overview):

The Charlottesville-Albemarle-Louisa-Greene Children and Youth Program was established to provide comprehensive health care for the indigent population of the area (from birth to 21 years of age). The entire program is directed by a pediatrician with the assistance of an administrator, and comprehensive health services for children within family groups are coordinated through a care team. This assures continuity of care, adequate follow-up and rational use of the Project.

The Children and Youth Program is in a unique position in the State of Virgina, existing as an arm of both the State Health Department and the University of Virginia. As such, the Children and Youth Program is able to provide comprehensive health care services to the indigent children of the area through a wide range of public health outreach programs and a stable multidisciplinary university health center. The latter provide access to consultant services in addition to allowing the Project to serve as a model for the future primary care physicians and nurse of the Commonwealth of Virginia.

Project Operation (Innovative Aspects):

The Charlottesville-Albemarle-Louisa-Greene Children and Youth Project provides medical services, including sick and well child visits, laboratory x-ray and prescription drugs. It also provides family planning services and other services through an Adolescent Clinic, which is the only one in the area. In addition, dental services, speech pathology, audiology, home economics, psychology, and social work are delivered, with the health educator, nursing and social service outreach teams assuring proper utilization of these services.

The Project serves 3,917 persons, representing 1,360 families. This is almost 50 percent of the eligible population and represents an increase of about 5 percent per quarter. Of this number, 1,091 are Medicaid recipients The age breakdown, moreover, follows that of the population as a whole.

In the almost ten years of the Program's existence, the Division of Medical Social Work and Division of Dentistry have been expanded. The Project assisted in the development of a mandated speech pathology program in Nelson County. Nurse practitioners were first brought to the University of Virgina Hospital by the Children and Youth Project, and there is now an active practitioner training program as well as widespread utilization of them. At the present time, there is discussion of the speech pathology section forming the nucleus of a center-wide Division of Speech Services. Thus, the Project has provided the population of central Virginia with access to services found nowhere else while, at the same time, intensifying the services available to other children at no increased cost.

On the community level, the Children and Youth Project has provided a site for the training of underemployed minorities, through the Neighborhood Youth Corps and CETA. The Project has also worked to coordinate community services so as to reduce costs and to educate the nonmedical professional and para-professional organization in health care issues in order to improve the communities' quality of life.

Results/Recommendations:

A formal evaluation of the Charlottesville-Albemarle-Louisa-Greene Children and Youth Program will be initiated at the end of the 1977 fiscal year. However, some of the notable accomplishments of the Children and Youth Project have included:

- Providing transportation services to patients that otherwise would not have access to medical services at a cost of under $.40 per mile or $7.79 per patient encounter.

- Providing health care services to almost 50 percent of the eligible population.

- Reducing the broken appointment rate for medical visits to less than twenty percent and the overall broken appointment rate to less than eighteen percent.

- Utilizing nurse practitioners instead of physicians at less than half the cost of a pediatrician and at a lower salary than a pediatric resident.

In summary, the Children and Youth Project has provided its target population with a high level of immunization in the community; it has significantly lowered the hospitalization rate, reduced emergency room visits and decreased problems with anemia from that which is evidenced in the indigent community as a whole. These children now have a stable group of health care providers with an identifiable physician and/or nurse practitioner which improves access to medical/health care.

For More Information:

Dr. Joseph Zanga, Director
Department of Pediatrics
University of Virginia Hospital
Charlottesville, Virginia 22901

Project Name:	The Greene County Dental Health Project
Project Location:	Standardsville, Virginia
Recipient Agency/Organization:	University of Virginia Hospital
Project Duration:	1971 - present
Projects Costs:	$110,000/year
Funding Source:	The Project was funded through the Virginia Department of Health under Title V of the Social Security Act. In addition, revenue is raised through third party payments.
Target Population:	Low income children and youth residing in Greene County, Virginia.
Project Goals:	·To demonstrate that effective, comprehensive dental care (prevention-oriented) can be provided to children and adolescents in an area of high concentration of rural, low income families. ·To educate the population of Greene County regarding sound dental health practices. ·To prove that quality dental care can be provided at reasonable cost.

Project Operation (Overview):

The Greene County Dental Health Project has been and continues to be a valuable part of the community it serves. It provides comprehensive dental care for an indigent, mostly rural, child and adolescent population. In addition to treatment of existing dental problems, great emphasis is placed on dental health education and prevention of dental disease.

The Project, which is located in Standardsville, Virginia, transports eligible individuals for care to and from the dental clinic facility. Patients requiring types of care (whether dental or medical) not available at the facility site, are referred and transported to the appropriate facility, usually at the University of Virginia in Charlottesville, Virginia.

The Greene County Dental Health Project fills a long-standing dental care void due to a low priority that most low income families place on dental care for their children and the long distances they were required to travel to reach available private or adult dental care facilities.

Dental health education and prevention in Greene County has received increased emphasis. The Project developed and implemented a dental health education program in the Greene County Public Schools which is being expanded to reach one new grade each year plus re-education for each of the grades started in previous years. The program is conducted by the Project's dental hygienist.

The Project has been and continues to be well accepted by the community. A close liaison is maintained with the community by means of the Greene County Dental Health Project Citizens' Advisory Committee composed of representatives of the local health and welfare departments, and interested citizens.

Project Operation (Innovative Aspects):

The Greene County Dental Health Project has recognized that because of the massive amount of dental disease that was encountered initially, it was necessary to establish incremental treatment priorities in order to render effective treatment within the limits of staff and budget. In the first year of the program, the eligible three year olds, first graders, sixth graders, and twelfth graders were screened and registered for comprehensive dental care. After these age or grade groups were under care, other grade groups were treated. Each succeeding year the above-mentioned age and grade groups were brought into Project care. Emergency care, as needed, was available to all preschool and school-age children.

Dental health education and preventive dental care has been an integral part of the Greene County Dental Health Project and includes continued emphasis on brushing techniques, flossing instruction, and dietary education.

Most of the dental health education and preventive care take place at the Project facility, but education occurs in the schools under supervision of the Project dental hygienist or is carried into the home by the Project family health worker.

Over the past few years the population of Greene County has increased with the influx of new families. Information about the Project's dental services was recently distributed in the schools and a number of new, eligible families have requested their children receive dental care and more are expected. There will be periodic promotion of the services available to inform the new families.

Results/Recommendations:

The Greene County Dental Health Project will be evaluated by the Virginia Department of Health upon conclusion of the Federal fiscal year, September 30, 1977. The project will be evaluated along the following lines as delineated in the original proposal:

1. The effectiveness in bringing the eligible population to a state of dental health maintenance is measured by dividing the total eligible population into the number of registrants who have reached the status of dental health maintenance.

2. Cost effectiveness is measured from a cost/benefit analysis, which compares the costs which the Project incurs to the benefits which derive from the services the Project provides.

3. Broken appointment rate:

   Percentage of broken appointments is measured by dividing the total number of appointments into the number of broken appointments.

4. Caries Data:

   a.) Cavity surfaces per patient:

   Divide the number of patients with permanent teeth into the number of carious permanent tooth surfaces. This may also be done for average carious deciduous tooth surfaces per patient.

   b.) D.M.F. teeth (deciduous and permanent): Divide the total number of patients into the total number of decayed, missing, and filled teeth to arrive at the average D.M.F. for the Project population.

As of June 30, 1977, the number of Project registrants will total 1,085. Of the first 927 registrants for which comprehensive data are available, 878 (94.7 percent) were found to have dental cavities on their first annual treatment series examination; and, of the registrants with cavities, 630 (71.8 percent) had received no previous restorative dental treatment.

The Greene County Department Dental Health Project anticipates continuing the present level of activities without any change in quality or scope. The workload will remain essentially the same for the hygienist whose time will be reduced from 80 percent to 60 percent and the family health worker who will work half-time rather than full-time.

For More Information:

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Project Name:	Infant Intensive Care Project
Project Location:	Nassawadox, Virginia and Norfolk, Virginia
Recipient Agency/Organization:	Children's Hospital of the King's Daughters
Project Duration:	1974 - present
Project Costs:	$74,972 (for fiscal year 1977)
Funding Source:	The Project is funded through the Virginia Department of Health under Title V of the Social Security Act. In addition, revenue is raised through third party payments.
Target Population:	Infants who are born into low income families or who are potentially at risk during the first year of life.
Project Goals:	•To reduce infant mortality and morbidity by providing specialized outpatient and follow-up care for infants who are born at risk, who are potentially at risk or who become at risk during the first year of life. •To obtain adequate staff to meet the intensive outpatient follow-up needs of all infants in the community identified as being at risk. •To provide appropriate training for Health Department personnel involved in caring for high risk infants. •To provide for high risk infants appropriate referral for outpatient care by pediatricians and hospital care when indicated. •To continue close relationship with Childrens' Hospital of King's Daughters in order to inform them about the conditions of the home into which the high risk infant is to be received and to prepare the home and parents to receive the infant.

- To develop an accurate data collection system to record the number of infants being seen and the number of visits made.

Project Operation (Overview):

Since 1974, the Infant Intensive Care Project has provided intensive follow-up care for high risk infants discharged from the Neonatal Intensive Care Unit of Children's Hospital of the King's Daughters in Norfolk, Virginia. Liaison has been arranged between Children's Hospital and public health nurses in order to keep the public health nurse informed about the progress of high risk infants expected to be discharged to their homes. A public health nurse assesses the home to which an infant is to be discharged and informs the hospital liaison nurse as to the condition of the home and the attitude of the parents. The public health nurse assigned to an infant reviews a copy of the local pediatrician's discharge summary and begins intensive home visiting as soon as the baby is discharged, working closely with the pediatrician.

In addition, other infants possibly at risk are identified from birth certificates and are followed closely. These are:

a) infants of mothers 17 years of age or younger
b) infants under 5 lbs. 8 oz. at birth
c) infants of unwed mothers
d) infants of mothers with less than 8th grade education
e) infants born at home
f) products of difficult or prolonged labor
g) twin deliveries
h) deliveries by caesarian section

Finally, the project identifies and provides services to infants in well-baby or pediatric clinics who fail to thrive or have repeated hospitalizations.

Project Operation (Innovative Aspects):

The Infant Intensive Care Project was developed in an effort to address the issues originally identified in a health study conducted in 1972 by the Medical College of Virginia, School of Hospital and Health Administration, which revealed that the Eastern Shore of Virginia had the highest infant mortality rate of all the Planning Districts in the Commonwealth of Virginia (39/1000 live births vs. 20.5/1000 statewide - 1971). Although the 1974 data showed a decrease to 24.6/1000 live births as opposed to 17.4 statewide, the Eastern Shore still had a higher infant death rate than any other district in Virginia. In addition, the Eastern Shore Mental Health Study (1976) found that "the resident population of the Eastern Shore is among the most impoverished, under educated, and unhealthy of all rural areas of the Commonwealth of Virginia and of all the rural areas in the United States".

The Infant Intensive Care Project was essentially designed to decrease the incidence of neonatal mortality and morbidity of the infants who were born to mothers on the Eastern Shore and in Tidewater, Virginia. The morbidity and

mortality of newborn infants was quite high because of the low socio-economic status of the population and the inadequate resources of this isolated community.

In the earlier phases of the Program, the monies were used for the acquisition of equipment needed in the Intensive Care Unit, and for the support of a neonatalogist. Last year the money was used for the addition of needed personnel in the perinatal division of Eastern Virginia Medical School. The division now consists of two neonatalogist, one perinatalogist, two nurse practioners, and four secretaries.

The pediatric nurse practitioner and neo-natalogist work closely together to coordinate community resources for the patient's benefit. The neo-natalogist has made periodic visits to the regional hospitals to give in-service education to health professionals and to help hospitals acquire the needed equipment to practice modern peri-natal care. The nurse practitioner has worked with the public health departments to improve the visiting nurse's assessment of the patient's home prior to discharge. She has also coordinated the infant's discharge so the family is familar with the patient's condition and all the social services. Public health nurses and medical consultants have completed their plans for continuing ourpatient care. She now uses a discharge summary form which is sent to the physician caring for the infant after discharge.

The social needs of the patients are partially met by the activities of the pediatric nurse practitioner. There are many problems that face the young family with a premature infant, and these are not being properly managed. To help reduce this problem the National Foundation of the March of Dimes has supported the position of a medical social worker.

Results/Recommendations:

The impact on perinatal care that the Project has made can be measured in several ways. The total number of neonatal admissions to Children's Hospital of the King's Daughters has increased to 324 admissions per year which represents 2.26 per cent of all civilian births in HSA Region V. The neo-natal mortality of all admissions to the Infant Intensive Care Project is 19 percent which compares favorably with the national statistics.

The Infant Intensive Care Project has been implemented by a staff of public health nurses. During the present biennium, it has been impossible to fill the special position, pediatrics or family nurse practitioner. Since recruitment for this special kind of nurse has been in process for two years without success, it has been necessary to lower the job requirements in order that a nurse can be recruited, hired and given special training to work in the field of high risk infant care. At present, the public health nurse staff is adequate to care for all infants discharged from Children's Hospital of King's Daughters, but is not adequate to visit all "possibly high risk infants" as indicated by reviewing birth certificates or to identify and follow those at greatest risk.

For More Information:

Dr. Madge May, Acting Director
Eastern Shore Health District
Cross Street
Nassawadox, Virginia 23413
or
Dr. Frederick Worth
Children's Hospital of the King's Daughter
609 Colley Avenue
Norfolk, Virginia 23507
(804/622-1381)

Project Name:	The Norfolk Children and Youth Program
Project Location:	Norfolk, Virginia
Recipient Agency/Organization:	Norfolk City Department of Public Health
Project Duration:	1970 - present
Project Costs:	$880,187 (for fiscal year 1977)
Funding Source:	The Project is funded through the Virginia Department of Health under Title V of the Social Security Act. In addition, revenue is raised through third party payments.
Target Population:	The Project's target population are the city's medically indigent, multi-problem, handicapped children and families who require comprehensive multi-disciplinary services.
Project Goals:	. To increase preventive health services (e.g. parenting competency, immunizations and nutrition) delivery. . To provide family planning services to all registered, and in need, teenagers desiring such services. . To expand maternal child health services. . To provide screening examination, other planned health care and illness care to eligible children.

Project Operation (Overview):

Now in its eighth year, the Norfolk Children and Youth Program has grown from a single building housing some 30 workers dealing with fewer than 2,000 clients on a comprehensive medical care basis, to a complex of three walk-in clinics in model cities areas, housing sixty-one full-time staff equivalents and serving over 7,400 children.

The Project provides comprehensive health services through a multi-disciplinary team approach in the six health areas of medical, dental, nursing, social services, speech and hearing and nutrition.

Service delivery is provided through: intake interviews, comprehensive pediatric screening examinations and assessments; early diagnosis and treatment services; coordinated referrals to community child service programs for personal health, environmental, social,and educational services; aftercare, and health supervision with routine preventive services; episodic care for internal illness and on-going health education. Mental health services are rendered through on-site outreach clinics of the Community Mental Health Center and Psychiatric Institute.

In addition to self-referrals from persons within Project areas, the Children and Youth Project has service arrangements with the following agencies: The Virginia Medical Assistance Program, Model Cities Neighborhood Centers, Norfolk Lead Poisoning Control Program, Concentrated Employment Program of Southeastern Tidewater Opportunity Project and the Norfolk Public Health Department.

Project Operation (Innovative Aspects):

Through improved, effectiveness and progressive cooperation of effort with its parent health department and dozens of outside agencies, the Project has become a care clinic for children of widely dispersed programs and agencies as well as self-referrals. Through contractual agreements the Project staff: provides preventive screening, diagnosis and treatment services to Medicaid eligible children and children enrolled in Headstart/Homestart programs; provides medical follow-up of children identified with increased lead absorption by Norfolk Lead Control city-wide screening: operates satellite clinics at two Model Cities/Human Resources Neighborhood Centers to make services more available and operates these programs along more flexible hours to make them more accessible to area residents; and conducts on-site public health training programs for local universities/colleges.

The Project has developed several specific innovative projects in order to reach the target population and community.

- Community programs of the Parent Study Groups (aimed at reaching mothers and fathers).

- Neighborhood Councils and a Consumer Advisory Group have been set up to encourage community participation in developing service delivery procedures.

- Pre-adolescent and Adolescent Groups are used to encourage children and youth to utilize services.

- An Adolescent Clinic has been set up to provide innovative prevention services and comprehensive health services specifically to adolescents.

- A pre-school stimulation program has been established for children with developmental delays and their parents.

Results/Recommendations:

A formal HEW evaluation will be conducted at the end of the fiscal year 1977-78.

Nevertheless, several notable accomplishments are already apparent. During the Project's 8 years of operation, funding has remained "fixed" - actually the present level of federal funding is 4% less than 1975; despite inflation. The Project has accomplished this through the establishment of common record keeping with agencies it works with, tracking of registered program participants, automation of information, common utilization of strategically placed field clinics and improved management and evaluation techniques.

Moreover, the Project has been highly successful in developing teen and pre-teen (normally, a high need but low utilization group) utilization of services. Overall, the Project has been able to encourage 22% of all eligible children in the city to participate in the program.

For More Information:

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Norfolk Children and Youth Project
425 West 35th Street
Norfolk, Virginia 23508

A LISTING OF FUNDING INFORMATION FOR
PROGRAMS FOR CHILDREN AND YOUTH

A Listing of Funding Information for Programs for Children and Youth

Burnham, Robert A., Henderson, Robert A. and McLure, William P. Special Education: Needs, Costs, Methods of Financing. Bureau of Educational Research, College of Education, University of Illinois at Urbanna-Champaign, 1975.

CWLA Hecht Institute for State Child Welfare Planning (1346 Connecticut Avenue, Washington, D. C. 20036) has the following publications available:

- Finding Federal Money for Children, 1975 ($6.00)
- Obtaining Federal Money for Children, 1976 ($6.00)
- Audit-proof Contracting for Federal Money for Children, 1976 ($6.00)

Day Care and Child Development Council of America, 1012 14th Street, N.W., Washington, D. C. 20005. Money for Migrant Children. 1973 ($1.50).

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Division of Youth Activities, Office of Youth Development, Office of Human Development, U. S. Department of Health, Education and Welfare. Catalog of Federal Youth Programs. U. S. Government Printing Office, Washington, D. C. 20402. 1976 ($2.25).

Executive Office of the President, Office of Management and Budget. 1974 Catalog of Federal Domestic Assistance. U. S. Government Printing Office, Washington, D. C. 20402.

This annual publication dealing with all Federal funding programs is particularly useful when attempting to identify potential Federal funding sources.

Grantsmanship Center News (1015 W. Olympic Blvd., Los Angeles, California 90015) has the following reprints available for distribution:

- Program Planning and Proposal Writing (1-10 copies - .75¢ each)
- How To Obtain Funding From Local Governments (1-10 copies - .75¢ each)
- Research Foundations: How To Identify Those That May Support Your Organization (1-10 copies - $1.25 each)
- Guide To New Federal Grant Administration Standards (1-10 copies - .75¢ each)
- Basic Grantsmanship Library (1-10 copies - .75¢ each)
- I Hate Charities (1-10 copies - .75¢ each)
- Guide To State Laws Regulating Fund Raising (1-10 copies - .75¢ each)

- Ten Steps To a Million-Dollars Fund Raiser (1-10 copies - .75¢ each)
- IRS and Charities (1-10 copies - $1.00 each)
- Guide To PR for NonProfits (1-10 copies - $1.00 each)
- How To Use the Catalog of Federal Domestic Assistance (1-10 copies - $1.00 each)
- The A-95 Proposal Review Process (1-10 copies - $1.00 each)
- Understanding Federal Management Circulars and the New Mix of Federal Assistance (1-10 copies - $1.00 each)
- The New Contractsmanship (1-10 copies - $1.00 each)
- Title XX (1-10 copies - $1.00 each)
- How Foundations Review Proposals and Make Grants (1-10 copies - $1.00 each)
- How To Develop a Fund Raising Strategy (1-10 copies - $1.00 each)
- FMC's New Uniform Federal Grant Administration Standards (1-10 copies - $1.00 each)
- City Hall An Important Resource For Your Organization (1-10 copies - .75¢ each)
- Guide To the New Grant Administration Standards for Nonprofits (you can obtain up to 25 copies free from the Publications Office, Office of Management and Budget, 726 Jackson Place, N.W., Washington, D. C. 20503
- Community Foundations (1-10 copies - $1.25 each)

Hall, M. Developing Skills in Proposal Writing. Corvallis, Oregon, Continuing Education Publication (1972).

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Law Enforcement Assistance Administration, U. S. Department of Justice, 633 Indiana Avenue, N.W., Washington, D. C. 20531. The Law Enforcement Assistance Administration : A Partnership for Crime Control, 1976.

Lewis, Marianna O. (ed.) The Foundation Directory. Irvington, New York, Columbia University Press (1975).

National Institute of Mental Health, 5600 Fishers Lane, Rockville, Maryland 20852. Support Programs. Health Services and Mental Health Administration, U. S. Department of Health, Education and Welfare.

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Norton, Craig and Norton, Peter. Everything You Can Get From the Government For Free...or Almost For Free. Van Nostrand Reinhold Company, 450 W. 33rd Street, New York, New York. 1975 ($7.95).

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Urgo, Lewis A., and Robert J. Corcoran. A Manual For Obtaining Foundation Grants. Boston, Massachusetts, Robert J. Corcoran Company (1971).

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A regularly updated, easy to use volume that groups grant programs by funding area (e.g., Health Field).

Women's Bureau, Employment Standards Administration, U. S. Department of Labor. Federal Funds for Day Care Projects, Washington, D. C. 1972 ($1.00 - available from the Superintendent of Documents, U. S. Government Printing Office, Washington, D. C. 20402).

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